



Return Signed RX via Fax to 443.977.6808

KabaFusion Enteral Referral Form

| | | | | | | | | | | | |
|--|----------|-----------------------------------|------------------------------|--------------------------|---------------------------------|----------------------|-----------|--------------------|----|-----|----|
| To: | | From: | | | | | | | | | |
| Intake Phone: 410.844.5502 | | Phone: | | Fax: | | | | | | | |
| Date: | | Number of Pages, Including Cover: | | | | | | | | | |
| Patient Name: | | Home Phone: | | | | | | | | | |
| Date of Birth: | | Name of Clinic: | | | | | | | | | |
| Patient Home Address: | | City: | | State | Zip | | | | | | |
| Diagnosis: | | | | Gender : | Male Female | | | | | | |
| Type of tube: | PEG | Low Profile Button | PEG/J | J-tube | First Dose? Yes No | | | | | | |
| Patient Eating? | Yes | No | Estimated Length of therapy: | | | | | | | | |
| Faxed copy of Placement: | Yes | No | Swallow test: | Yes | No | | | | | | |
| IV Access: | PICC | Port | Central | Other | Pump Required? Yes No | | | | | | |
| Has Patient been instructed on use of pump: | | | Yes | No | Other tests: | | | | | | |
| Hospital Discharge Summary attached? | | Yes | No | Most Recent Labs (date): | Attached: | | | | | | |
| Formula Name: | | Volume per day: | | Rate: | | | | | | | |
| Anticipated Start of Care Date: | | Delivery Due Date: | | | | | | | | | |
| Start of Care Date: | | | | Spanish-speaking Only | | | | | | | |
| History & Physical | Attached | Marital Status: | S | M | D | W | Diabetic? | Yes | No | | |
| HT: | WT: | Allergies: | | | | | | | | | |
| Other home health care needs? | | | | | | | | | | | |
| Physician signing discharge orders: | | | | Fax: | | Phone: | | | | | |
| Physician who will follow patient at home (if different than above): | | | | | | | | | | | |
| Physician Name: | | | | Fax: | | Phone: | | | | | |
| Patient demographics: | | Attached | Patient Cell Number: | | | Patient Work Number: | | | | | |
| Delivery address (if different than home): | | | | | | | | | | | |
| Emergency Contact Outside Home: | | | | Relationship: | | | Phone: | | | | |
| Caregiver Name: | | | Caregiver Teachable? | | Yes | No | Phone: | | | | |
| Patient Independent? | | Yes | No | Homebound? | | Yes | No | Patient Teachable? | | Yes | No |
| Insurance: | | | | ID# | | | Phone: | | | | |
| Medi-Cal ID#: | | | | Issue Date: | | | | | | | |
| Medicare D? | | Yes | No | Part D Plan: | | ID#: | | Phone: | | | |
| Is Initial Nutrition Assessment to be provided by a KabaFusion Registered Dietitian? | | | | | | Yes | No | | | | |

CONFIDENTIALITY NOTICE

The following includes confidential, proprietary information that is the sole exclusive property of KabaFusion Holdings, LLC. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of KabaFusion Holdings, LLC. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.

**KabaFusion Infusion Pharmacy | 8989 Herrmann Drive | Suite 140 | Columbia, MD 21045
Phone: 410.844.5502 | Fax: 443.977.6808 | www.kabafusion.com**