Certification of Enteral Nutrition

Please check if this is:

☐ Initial Certification

☐ Recertification

☐ Change in Prescription

Time Period From: Click or tap here to enter text.

To: Click or tap here to enter text.

1. Member Information:

A. Member Name Click or tap here to enter text.	B. Member State ID# Click or tap here to enter text.	C. Date of Birth Click or tap here to enter text.
D. Member Resides At: ☐ Home ☐ SNF ☐ ICF/MR ☐ Non-Skilled Facility		
E. Does member receive home health nursing services? ☐ Yes ☐ No		

2. Member General Condition:

F. Estimated Duration of Need for Enteral Nutrition ☐ MonthsClick or tap here to enter text. ☐ Years Click or tap here to enter text. ☐ Lifetime	
G. Member Height Click or tap here to enter text.	H. Member Weight Click or tap here to enter text.
I. Please list any therapies or treatments that may affect member's nutritional needs: Click or tap here to enter text.	

3. Clinical Assessment:

J. Please list all of member's diagnoses: Click or tap here to enter text.
K. Please describe member's functional impairment of the alimentary tract: Click or tap here to enter text.
L. Is Enteral Nutrition the only form of nutritional intake for this member? ☐ Yes ☐ No If no, please explain: Click or tap here to enter text.
M. Is the member able to tolerate liquefied or pureed foods? ☐ Yes ☐ No If no, please explain: Click or tap here to enter text.

N. Date that member was last seen by the physician: Click or tap here to enter text.

4. Enteral Nutrition:

O. Product Click or tap here to enter text.	P. Calories per day product: Click or tap here to enter text.	Q. Calories per day regular or pureed food: Click or tap here to enter text.
R. Frequency Fed: Click or tap here to enter text.	S. Method of Administration ☐ Syringe ☐ Gravity ☐ Pump	
T. If pump fed: Rate Click or tap here to enter text. Hours of duration Click or tap here to enter text.		
U. What is member's physical condition that necessitates use of pump rather than gravity? Click or tap here to enter text.		
V. Administration Technique: ☐ Nasogastric Tube ☐ Gastrostomy ☐ Jejunostomy ☐ Oral		

5. WIC Eligible:

W. Is member WIC eligible? ☐ Yes How many cans/month received: Click or tap here to enter text. ☐ No (Please attach a letter of denial from WIC if under age 5)

6. Certification:

X. Dr. Name Click or tap here to enter text.	Y. Specialty: Click or tap here to enter text.	Z. Phone number: Click or tap here to enter text.

Attending Physician Signature ____

Date Signed ________________