Home Parenteral Nutrition (PN) referral / Home start order form

Phone: _____

Fax: _____

PATIENT INFORMATION

Acute care specialist name:			Phone:
Patient: ☐ see attached Gender: ☐ Male ☐ Female			
Patient name:		DOB:	Last 4 of SSN:
Address:			City:
State:	ZIP:	Phone:	Cell:
Emergency contact:		Phone:	Relationship:

***IF MEDICARE PLEASE ATTACH/SEND ALL MEDICAL DOCUMENTATION INCLUDING ESTIMATED LENGTH OF NEED FOR PN DOCUMENTED IN MEDICAL RECORD BY ATTENDING PHYSICIAN. NOTE: COVERAGE WITH MEDICARE IS NOT GUARANTEED.**

Desired start date:	Home health nursing or preferred agency, if not Optum:		
Central access: ☐ Yes ☐ No | ☐ PICC ☐ PORT ☐ Tunneled catheter Attach documentation			
Insurance: ☐ Front and back of insurance card to follow			
Primary Insurance:	Phone:	Policy #:	Group:
Secondary Insurance:	Phone:	Policy #:	Group:

PRESCRIPTION AND ORDERS

Required labs: *(CMP, magnesium, phosphorus, CBC with differential)* ☐ Yes ☐ No

If not, draw above labs PRIOR to initiation of PN Date of labs: _____

Select the following starting prescription (per 24 hours) for the first _____ days of PN:

☐ 1 Liter of Clinimix® E 4.25/5

50g Dextrose 42.5g Amino acids 35 mEq Sodium 30 mEq Potassium 4.5 mEq Calcium 15 mM Phosphorus
5 mEq Magnesium 10 ml IV MVI 1 ml MTE-Conc 100mg Thiamine

☐ **2 Liter of Clinimix® E 4.25/5**

100g Dextrose 85g Amino acids 70 mEq Sodium 60 mEq Potassium 9 mEq Calcium 30 mM Phosphorus
10 mEq Magnesium 10 ml IV MVI 1 ml MTE-Conc 100mg Thiamine

☐ _____ Liter

☐ g Dextrose ☐ g Amino acids ☐ mEq Sodium ☐ mEq Potassium ☐ mEq Calcium ☐ mM Phosphorus
☐ mEq Magnesium 10 ml IV MVI 1 ml MTE-Conc 100mg Thiamine

☐ **Nursing/lab orders**

Required labs to be drawn 48 hours after initiation of PN: *(CMP, magnesium, phosphorus)*

Cycle PN: initially at 18 hours with a programmed 1 hour taper up and 1 hour taper down

Flush CVAD: 0.9% Sodium Chloride 10mL before and after infusion. Lock CVAD with Heparin 10units/mL or *(if PORT)* 100units/mL 5mL as a final lock for patency.

Nursing to assess patient, teach PN adminstration, draw lab work, and perform weekly dressing changes

Pharmacy to dispense flushes, syringes, needles, HME/DME, in quantity sufficient to complete prescribed therapy

PHYSICIAN INFORMATION

Name:		Practice:		
Address:		City:	State:	ZIP:
Phone:	Fax:	NPI:	Contact:	

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and lab ☐ TB results

Signature: _____ Date: _____