WessCare, LLC.
Home Medical Equipment

Phone: (731) 836-1111
Fax: (731) 836-1006

Physician Order for Enteral Nutrition

Patient Name: _____Height_____Weight_____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____)_____

Diagnosis Code(s):_____ Physicians Phone_____

Patients current Primary Care Physician. _____

Does WIC Provide ❒ YES ❒ NO If yes how much _____

Please check if you desire you patient to be set up with:

❒ Formula

Brand_____

Ounces per day _____

Feeding Route_____ Rate_____

❒ Feeding Supplies

- ❒ 60cc Syringes Quantity per month _____
- ❒ Gauze Type_____ Quantity per month _____
- ❒ Extension Type_____
- ❒ Button Size _____
- ❒ G-Tube Size_____
- ❒ Mushroom Catheters Size_____
- ❒ Tape Quantity_____Type_____

_____ _____

Physician Signature Date Duration of services needed

_____ Substitution allowed _____ Dispense as written

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