

Return Signed RX via Fax to 888.966.0416

KabaFusion Enteral Referral Form

To: Fidelis Fynn, Pharm.D.				From:					
Intake Phone: 888.727.2323				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		

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