REQUEST FOR ENTERAL NUTRITION PRODUCT(S) AND EQUIPMENT

PATIENT INFORMATION Please completely fill out this form for requests for enteral nutrition products and supplies. FAX this form with required documents to Oso Home Care.

PHARMACY VENDOR Oso Home Care, Inc. **PHONE** (949) 660-7126 **FAX** (818) 433-7662

PATIENT NAME _____ **DOB** _____

ELIGIBLE MEDICAL CONDITION (DIAGNOSIS) _____ **ICD CODE:** _____

NUTRITION PRODUCTS:

Full Product Name *Including caloric concentration and fiber (when applicable)*	**11 Digit Product Code***	**Delivery Route** (Circle)**	**Amount**		**Duration (Max = 6 mo.)**
			Liquid (ml)	**Power (g)**	
		OR TF	24 hr: 1 mo:	24 hr: 1 mo:	
		OR TF	24 hr: 1 mo:	24 hr: 1 mo:	
		OR TF	24 hr: 1 mo:	24 hr: 1 mo:	

***11 Digit Product Code: Use current Medi-Cal Provider Manual** ** ***Delivery Route:* OR** = *Oral,* **TF** = *Tube Feeding*

Equipment and Supplies: (Pumps, IV Pole, Feeding sets, Gauze, syringes, etc.)

Full Product Name	**Code**	**Quantity**

For use with pump: **Rate:** _____ **ML/HR** **Hrs per Day:** _____

RD name (print): _____ **Phone:** _____ **Email:** _____

Physician name (print): _____ **License#:** _____

Phone: _____ **Fax:** _____

Physician Signature: _____ **Date:** _____

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