Complete and print.

Reset Form

MAYO CLINIC

Enteral Prescription

Mayo Clinic Store

Form content not retained in medical record.
Route to Mayo Clinic Store for electronic storage.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic or Store Account Number

External Form Users:
Complete this document **in black ink** and fax to the Mayo Clinic Store.

Internal Epic Downtime Form Users:
Complete this document and fax to the Mayo Clinic Store. Once Epic downtime processes are complete, reenter order into the EHR and send an Epic message to the Mayo Clinic Store's inbasket pool informing them that a duplicated order was created.

Order Information

Order Date *(mm-dd-yyyy)*	Need Length ☐ Lifetime ☐ Other		Qualifying Diagnosis (ICD-10)
Date Last Seen *(mm-dd-yyyy)*	Current Height (cm)	Current Weight (kg)	Date Taken *(mm-dd-yyyy)*
Patient Address *(Street, City, State, ZIP Code)*			Patient Phone
Enteral Therapy Start Date *(mm-dd-yyyy)*	Is this the patient's only form of nutrition? ☐ Yes ☐ No If no, what percent of total calories are from the supplement? %		
Quantity of Prescribed Supplement per 24 Hours Number of cans or milliliters			
Prescribed Calories per 24 Hrs	Brand of Enteral Nutrition	Has patient experienced recent weight loss? ☐ Yes ☐ No If yes, patient lost pounds over months.	
Is patient tube fed? ☐ Yes ☐ No If yes, when was tube placed? *(mm-dd-yyyy)*		Feeding Tube Type	
Administration Method ☐ Syringe ☐ Gravity ☐ Pump ☐ Oral		Is there documentation in the medical record supporting this patient having permanent (3 months or longer) non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? ☐ Yes ☐ No	
Number of Days per Week Administered			

Equipment Order (For Mayo Clinic Staff Use Only)

Item or Description	Quantity	Procedure Code

Place of Service	Name of Facility

Referring Provider Information and Signature

Facility	Phone	Fax
Provider Signature ▶ Signature Required		Date *(mm-dd-yyyy)*
Provider Printed Name *(First, Middle, Last)*		National Provider Identifier

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

Print