Physician's Written Order

FreeArm Muscle Enteral Device

To dispense once with 0 refills

Fax this form to your patient's current home medical supplier.

PATIENT

First | MI | Last

DOB | Gender

Street | City | State | Zip

Phone | Email

Caregiver Contact | Phone | Email | Relationship

PRESCRIBING PHYSICIAN

First | MI | Last

Street | City | State | Zip

Phone | Fax | NPI#

DIAGNOSIS REQUIRING TUBE FEEDING AND/OR INFUSIONS: (check all that apply)

Start Date:_____/_____/_____ Estimated Length of Need_____months (99 = lifetime) ICD-10 Diagnosis Code:_____

☐ ALS ☐ Cancer ☐ Failure to Thrive ☐ Gastroparesis ☐ Unable to Swallow/Aspiration

☐ Other _____

1. Route of enteral and/or parenteral nutrition: (check all that apply)

☐ Gastrostomy Tube ☐ Jejunostomy Tube ☐ G/J Tube ☐ Nasogastric Tube ☐ Port

☐ Other_____

2. Method of administrating enteral or parenteral nutrition: (check all that apply)

☐ Syringe ☐ Pump ☐ Gravity

3. Justification for need of FreeArm Muscle: (check all that apply)

☐ Two story house, cannot carry IV pole up/down stairs ☐ Need for mobility while tube feeding ☐ Need for standardized feeding rate

☐ Muscle weakness/unable to hold gravity syringe ☐ Use of wheelchair/unable to move IV pole ☐ Retching or vomiting

☐ Other_____

Medical records may be required for insurance coverage

I certify that I am the physician/practitioner identified on this form and I have reviewed the Physicians Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician/Practitioner Signature:_____ Date: _____

(Stamps are not acceptable)

Printed Name: _____