Lincare
Enteral Therapy

LINCARE
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Standard written order.

Fax the completed SWO, patient's demographics, insurance information, and supporting clinical records to Lincare at **800.473.0578.**

Patient name:		DOB:
Order Date:	LON (Months): ☐ 3 ☐ 6 ☐ 12 ☐ 99 ☐ Other: _____	
Patient height:	Patient weight:	
Diagnosis ICD-10 codes:		
Formula name		**Calories/day**
☐ May use nutritionally comparable formula	☐ Attached medical necessity justification for specialty enteral formulas (B4149, B4153, B4154, B4155, B4157, B4161, B4162)	
Route	☐ Feeding tube	☐ Oral nutrition
Method of administration	**Access**	**Replacement feeding tubes**
☐ B4034: Syringe supply kit/day ☐ B4036: Gravity supply kit/day ☐ E0776: IV pole qty. 1 ☐ B4035: Pump supply kit/day ☐ B9002: Pump qty. 1 ☐ E0776: IV pole qty. 1 Pump rate: _____ mL/hr. ☐ Attached pump medical necessity justification **Water flushes:** _____mL every_____hrs.	☐ NG ☐ NJ ☐ ND ☐ G-tube ☐ J-tube ☐ G/J-tube ☐ G-tube low-profile ☐ G/J-tube low-profile **Connection type** ☐ Enfit ☐ Legacy (Cath tip) **Additional tube supplies** ☐ B9998: Extension sets _____ per month	☐ B4088: Low-profile G-tube Size: _____FR_____CM Qty:_____every_____months ☐ B4087: Standard G-tube Size: _____FR_____mL Qty:_____every_____months ☐ B4081: NG tube w/stylet Size: _____FR_____CM Qty:_____per _____month ☐ B4082: NG tube w/o stylet Size: _____FR_____CM Qty:_____per _____month
Additional supply items		**Qty/month**
Ordering practitioner		
Phone:	Fax:	
Practitioner name:		NPI#:
Practitioner signature:		Date: