



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): <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 <input type="checkbox"/> 99 <input type="checkbox"/> Other: _____	
Patient height:	Patient weight:	
Diagnosis ICD-10 codes:		
Formula name		Calories/day
<input type="checkbox"/> May use nutritionally comparable formula		<input type="checkbox"/> Attached medical necessity justification for specialty enteral formulas (B4149, B4153, B4154, B4155, B4157, B4161, B4162)
Route	<input type="checkbox"/> Feeding tube	<input type="checkbox"/> Oral nutrition
Method of administration	Access	Replacement feeding tubes
<input type="checkbox"/> B4034: Syringe supply kit/day <input type="checkbox"/> B4036: Gravity supply kit/day <input type="checkbox"/> E0776: IV pole qty. 1 <input type="checkbox"/> B4035: Pump supply kit/day <input type="checkbox"/> B9002: Pump qty. 1 <input type="checkbox"/> E0776: IV pole qty. 1 Pump rate: _____ mL/hr. <input type="checkbox"/> Attached pump medical necessity justification Water flushes: _____ mL every _____ hrs.	<input type="checkbox"/> NG <input type="checkbox"/> NJ <input type="checkbox"/> ND <input type="checkbox"/> G-tube <input type="checkbox"/> J-tube <input type="checkbox"/> G/J-tube <input type="checkbox"/> G-tube low-profile <input type="checkbox"/> G/J-tube low-profile Connection type <input type="checkbox"/> Enfit <input type="checkbox"/> Legacy (Cath tip) Additional tube supplies <input type="checkbox"/> B9998: Extension sets _____ per month	<input type="checkbox"/> B4088: Low-profile G-tube Size: _____ FR _____ CM Qty: _____ every _____ months <input type="checkbox"/> B4087: Standard G-tube Size: _____ FR _____ mL Qty: _____ every _____ months <input type="checkbox"/> B4081: NG tube w/stylet Size: _____ FR _____ CM Qty: _____ per _____ month <input type="checkbox"/> 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:

This telecopy transmission may contain confidential information belonging to the sender which is legally privileged. The information on this transmission intended only for the use of the person or entity named above. If the receiver of this transmission is not the intended recipient, please be advised that any use, disclosure, dissemination, distribution or copying of the information in this communication may be prohibited by law, including the health insurance portability and accountability act, which provides federal civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received this transmission in error, please notify the sender by telephone immediately.