DELTADRUGS

Gastrostomy

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 800.700.6401 • **FAX:** 866.700.6401 • info@deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Address: _____
Address, City, State, Zip Code

Phone #: _____ Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Phone #: _____ ID#: _____ Phone #: _____

NUTRITION PRODUCTS

PRODUCT	QTY	DURATION
❑		
❑		
❑		
❑		

EQUIPMENT AND SUPPLIES

PRODUCT	CODE	QTY
❑ PUMP ❑ RR ❑ NU	B9002	
❑ BAGS ❑ Infinity ❑ Joey ❑ Gravity	❑ B4035 ❑ B4036	
❑ G-TUBES ❑ GJ Tube ❑ NG Tube ❑ G Tube	❑ B4087 ❑ B4081 ❑ B4088	
❑ EXTENSIONS	B9998	
❑ IV POLE ❑ RR ❑ NU	E0776	
❑ 60CC CATH. TIP SYRINGES ❑ ST ❑ LL	A4322	
❑ SLIP TIP SYRINGES ❑ 1 cc ❑ 3 cc ❑ 5 cc ❑ 10 cc ❑ 20 cc	A4657	
❑ SLIT GAUZE ❑ 2x2 ❑ 4x4	A6402	
❑ LUBRICANT	A4402	
❑ TAPE	A4450	
❑ GLOVES ❑ Small ❑ Medium ❑ Large	A4927	
❑		

CLINICAL INFORMATION

ICD-10 Diagnosis

❑ _____

❑ _____

❑ _____

Clinical Notes to justify need for prescribed items:

_____

_____

_____

FAX COPY OF ALL RELATED CLINICAL/LAB INFO (WITHIN THE LAST 90 DAYS)

PHYSICIAN INFORMATION

Authorization period from: _____ To: _____ Refills: _____

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

BY SIGNING, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to any insurer or authorized agents, if required.