Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Enteral and TPN Nutrition Assessment / Follow-up Form

Today's date: _____

Complete this form and fax it to one of these numbers:

For BCN HMO℠ (commercial) members 1-866-313-8433 // For BCN Advantage℠ members: 1-866-578-5482

AGENCY INFORMATION	
Agency name:	
Contact name:	Contact phone number:

MEMBER INFORMATION	
Member name:	Authorization number:
Enrollee ID number:	Weight: _____ Height _____
Member date of birth:	Ideal body weight:
Start of care date:	Change in weight:
Ordering physician:	
Recent changes in the member's medical condition:	
Recent changes in the member's skin integrity:	
Additional comments about member's condition:	

ENTERAL FEEDING INFORMATION		TPN FEEDING INFORMATION
Date of last assessment:		Date of last assessment:
Current diagnosis related to need for tube feeding:		Current diagnosis related to need for TPN feeding (include why TPN is needed and oral or enteral feedings cannot be used):
Current tube-feeding prescription (include number of cans/day):		
GI access / tube:		Current TPN prescription:
B codes: _____ _____	S code for: ☐ Bolus: _____ ☐ Gravity: _____ ☐ Pump: _____	S code:
		Access line:
Tube feeding provides -- _____ Kcal/day and _____ gms protein/day		TPN feeding provides -- _____ Kcal/day and _____ gms protein/day
Oral intake provides -- _____ Kcal/day and _____ gms protein/day		Oral intake provides -- _____ Kcal/day and _____ gms protein/day
Estimated nutritional needs -- _____ Kcal/day and _____ gms protein/day		Estimated nutritional needs -- _____ Kcal/day and _____ gms protein/day

Registered dietitian who completed the form: