ameripharma SPECIALTY CARE

Total Parenteral Nutrition Referral Form

P: (877) 778-3308 F: (877) 778-0399

Patient Information

Patient's Full Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

Patient's Social Security Number: _____ Patient's Date of Birth: _____

Allergies: _____

Patient's Gender: ☐ M ☐ F

Prescriber Information

Prescriber's Name: _____

DEA: _____ NPI: _____

Address: _____ City, State, Zip: _____

Phone: _____ Alternate Phone: _____

Fax: _____ Email: _____

Please fax a copy of insurance card (front & back), chart notes, and recent labs

Diagnosis

☐ K56.60 Bowel Obstruction
☐ K95 Complications of Bariatric Procedures
☐ K50 Crohn's Disease
☐ K63.2 Enterocutaneous Fistula
☐ K31.84 Gastroparesis
☐ O21.1 Hyperemesis Gravidarum
☐ K90 Malabsorption
☐ K86.1 Pancreatitis
☐ K91.2 Small Bowel Syndrome
☐ Other: _____

Patient Evaluation

Has patient previously received TPN? ☐ Yes ☐ No

Patient Weight: _____ ☐ Kg ☐ Lbs.

Patient Height: _____ ☐ cm ☐ in

Allergies: _____

Delivery Method: ☐ Infusion Pump ☐ Other: _____

Line Access:

☐ Hickman ☐ Broviac ☐ Groshong ☐ Port ☐ PICC

Therapy Start Date: _____

Therapy End Date: _____

Medication Orders (Format-A)

☐ Days per week: _____

☐ Cyclic: Infuse over _____ hours (Taper up and down x1 hour) ☐ Continuous (24 hours/day)

Macronutrient Components:

☐ Clinimix (5/15) 2000 ml (Amino Acids 5% / Dextrose 15%) - **Recommended for patients > 65 kg**

☐ Clinimix (4.25/10) 2000 ml (Amino Acids 4.25%/Dextrose 10%) - **Recommended for patients < 65 kg**

☐ Custom Formula

Amino Acids (4 kcal/gm) _____% Dextrose (3.4 kcal/gm) _____% Volume (excludes lipids): _____

Lipids (1.1 kcal/ml; 2 kcal/ml; 3 kcal/ml) (☐ **10%** ☐ **20%** ☐ **30%**): ☐ _____ Grams Per Day

Frequency: ☐ Daily ☐ Twice weekly ☐ Three times weekly ☐ Other: _____

Dextrose / Carbohydrates (☐ **30%** ☐ **50%** ☐ **70%**): ☐ _____ Grams Per Day

Electrolytes:

☐ ***Standard:***

- Sodium 35 mEq / L
- Potassium 30 mEq / L
- Magnesium 5 mEq / L
- Calcium 4.5 mEq / L
- Phosphate 15 mMol / L
- Acetate 80 mEq / L
- Chloride 39 mEq / L

☐ ***Custom (specify amount of each electrolyte)***

- Sodium: _____ mEq (60-100 mEq)
- Potassium: _____ mEq (60-100 mEq)
- Magnesium: _____ mEq (10-20 mEq)
- Calcium: _____ mEq (9-18 mEq)
- Phosphate: _____ mEq (20-30 mEq)
- Acetate: _____ mEq (Acid-Base balance)
- Chloride: _____ mEq (Acid-Base balance)

Revised: 05/2025

Additives: Check all required additives and specify amount

- ☐ Multivitamin (MVI-12) ○ 10 ml / day ○ ____ ml / day
- ☐ Trace Elements: ○ 1 ml / day ○ ____ ml / day
- ☐ Regular Insulin: _____ units / day
- ☐ Famotidine: _____ mg / day
- ☐ Ranitidine: _____ mg / day
- ☐ Ascorbic Acid: _____ mg / day
- ☐ Folic Acid: _____ mg / day
- ☐ Other: _____

Medication Orders (Format-B)

- ☐ Sodium Chloride: _____ mEq / Day
- ☐ Sodium Acetate: _____ mEq / Day
- ☐ Sodium Phosphate: _____ mmol / Day
- ☐ Potassium Chloride: _____ mEq / Day
- ☐ Potassium Acetate: _____ mEq / Day
- ☐ Potassium Phosphate: _____ mmol / Day
- ☐ Calcium Gluconate: _____ mEq / Day
- ☐ Multivitamin MVI Adult: _____ ml / Day
- ☐ Trace Elements: _____ ml / Day
- ☐ Regular Insulin: _____ units / Day
- ☐ Amino Acids: _____ grams / Day
- ☐ Dextrose: _____ grams / Day
- ☐ Lipids: _____ grams / Day
- ☐ Total Volume: _____ ml / Day
- ☐ Infuse Over: _____ hrs / Day
- ☐ Infuse: _____ days / Week
- ☐ Total Calories: _____ Kcal / Day

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.

I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Prescriber's Signature (No Stamps): _____ Date: _____