Referral for Home Initiation of Total Parenteral Nutrition (TPN)

Georgia Patients: Contact 678-627-0077 fax 855-557-9440

Florida Patients: Contact 352-333-2525 fax 888-276-7948

Please provide us with the following information about the patient, so we can begin the work up to confirm the patient will meet requirements to start TPN at home. Please note that it could be up to 1 week or more before TPN is initiated. If the patient is found to be unsafe for home start or too high of a refeeding risk, we will let you know, and they should then be admitted for initiation of TPN.

Patient Information:

Name (first and last): _____

DOB:_____ **Height:**_____ **Weight (in pounds):**_____

Diagnosis/Indication for TPN therapy _____

Line Access (please check one):

PORT _____ PICC_____ Other _____ Number of Lumens: _____

Central Line Placement is pending, will be placed on: _____

*Please note that a patient must have a central line prior to initiation of TPN, midlines or peripherals are not acceptable

Documents to be included with this form:

- ❑ Demographics/insurance
- ❑ Line placement report (Please arrange for copy of line placement report to be sent to us if scheduled)
- ❑ Last office note from ordering provider (must have seen patient within the last 2 weeks) *Note: if patient is Medicare additional documentation may be required to qualify them for coverage.
- ❑ Current labs to include CBC, CMP, Magnesium, Phosphorus, & Triglycerides done within one week of TPN initiation. If no current labs are available, please order/arrange for patient to have them done prior to TPN initiation. *Note: if labs are outside of normal limits they may need to be replaced and rechecked prior to TPN initiation based on risk of refeeding syndrome.

Provider information:

Provider Name: _____NPI number: _____

Phone: _____ Fax: _____ Contact Person in office_____

By signing below, you are authorizing us to contact the patient and complete the initiation check list and a nutrition assessment. TPN order to follow with recommended initial formula will be sent for signature once complete.

Provider's Signature_____ **Date:** _____