

Authorization Form
TPN (Total Parenteral Nutrition)
Fax Form To: 616 975-8885
Attn: Home Health Care



Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____
Requesting Physician: _____ Phone: _____
Agency: _____ Phone: _____
ICD-9 Code/Diagnosis: _____

Clinical Information

Was part of the bowel removed? If so, amount remaining? _____

Part removed? _____

- Yes** **No** Is the member able to take any regular solid food by mouth?
- Yes** **No** Is adequate nutritional intake possible via oral or tube feeding?
- Yes** **No** Does the clinical record demonstrate that the member cannot be maintained on enteral feedings?
- Yes** **No** Has 10% of body weight been lost over 3 months or less?

Amount of Weight Loss: _____ Dates: _____

HT: _____ WT: _____ Goal Weight: _____

Current albumin: _____

Current pre-albumin: _____

Reason TPN Ordered

- Yes** **No** To increase protein or calorie intake in addition to the member's diet?
- Yes** **No** For routine pre- and/or post-operative care?
- Yes** **No** TPN calories per day are 750 or less?
- Yes** **No** The member have a structural or functional GI disease or condition?

Has the member

- Yes** **No** **N/A** Tried modifying the nutrient composition of diet?

Describe: _____

- Yes** **No** **N/A** Tried utilizing pharmacologic means to treat the etiology?

Describe: _____

RN Visits

How many RN visits needed for teaching? _____

How many RN visits needed for catheter care? _____

TPN

Duration of Treatment: Start Date: _____ **End Date:** _____

Dose: _____ **Rate:** _____