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Providence HEALTH CARE

Provincial Health Services Authority
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BC HOME ENTERAL NUTRITION (HEN) PROGRAM APPLICATION (ADULT PATIENTS)

* 9 5 5 8 *

Referral Other

BC Home Parenteral and Enteral Nutrition Programs
1081 Burrard Street, Vancouver, BC V6Z 1Y6 **Phone:** 604-806-9353 **Fax:** 604-806-8044

Use this application for clients aged 19 years or older.

This application form must be completed in full and faxed to 604-806-8044 with all required documents.
Please contact the HEN Dietitian at 604-806-9352 if you have questions about the application.

Date of Application: _____

DOES YOUR PATIENT MEET THE FOLLOING CRITEREIA FOR THE PROGRAM?		
Answers to the following questions must be provided for applications to be considered	**YES**	**NO**
Does the patient have a disease requiring a semi-elemental/elemental product? If yes, which disease? _____	☐	☐
Are the patient's nutritional requirements met solely with: • A semi-elemental/elemental product or • A semi-elemental/elemental product and TPN?	☐	☐
Did the patient fail a 5-day trial of a polymeric product: • Which product? _____ • What were the indications that the patient did not tolerate a 5-day trial of the polymeric product? _____ • If a trial of a polymeric product is contraindicated, please indicate why: _____	☐	☐
If an elemental product is required, did the patient fail a 5-day trial of a semi-elemental product? • Which product? _____ • What were the indications that the patient did not tolerate a 5-day trial of the semi-elemental product? _____ • If a trial of a semi-elemental product is contraindicated, please indicate why: _____	☐	☐

REFERRING PHYSICIAN:

Name (PRINT): _____ Specialty: _____

Signature: _____ MSP #: _____

Phone: _____ Fax: _____

Email: _____

DIETITIAN (if applicable)

Name (PRINT): _____ Specialty: _____

Signature: _____ College ID #: _____

Phone: _____ Fax: _____

Email: _____

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Referral Other

PATIENT INFORMATION:

Name: (Last) _____ (First) _____ (Middle) _____

DOB: _____ PHN: _____ Gender: ☐ Male ☐ Female

Address: (Street, Apt, Buzzer #) _____ ☐ Other: _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Email: _____

Alternate Contact: _____ Relationship: _____ Phone: _____

DELIVERY ADDRESS: (If different than above) **(please note: a PO box cannot be used for deliveries)**

Address: (Street, Apt, Buzzer #) _____

City: _____ Province: _____ Postal Code: _____

PRIMARY DIAGNOSIS: _____

MEDICAL SUMMARY: (Attach any relevant medical consult notes or reports) _____

MEDICATIONS: _____

Height: _____ cm Weight: _____ kg Date measured: _____

Total estimated energy requirements: _____ kcal/day

CURRENT NUTRITION TREATMENT:

Access: ☐ Naso-gastric ☐ Naso-jejunal ☐ PEG ☐ PEG-J ☐ Oral

Regime: _____

Feeding schedule: ☐ Nocturnal ☐ Intermittent ☐ Continuous

Administration method: ☐ Pump ☐ Gravity ☐ Oral

Please attach enteral feeding supply list (if applicable). Note that the HEN program does not provide enteral feeding pumps.

Formula: _____

Formula concentration: _____

Total volume per day: _____

Anticipated treatment duration: (Approval will only be given for a maximum of 6 months) _____

PATIENT/CAREGIVER AGREEMENT

I agree to:
- Accept home training when it is recommended.
- Release medical information to the HEN program. All medical information will remain strictly confidential.

_____ _____ _____

Patient/Caregiver signature | Printed name | Date

The BC Home Enteral Nutrition Program is unable to guarantee the length of time required to process an application and if approved, the length of time to have the product and supplies delivered. Product and supplies required prior to receipt of the first shipment are the responsibility of the patient/caregiver.

For Home Enteral Nutrition office use only

☐ Approved ☐ Non approved Signature: _____ Date: _____

Reason: _____