BC HOME ENTERAL NUTRITION (HEN) PROGRAM APPLICATION (PEDIATRIC PATIENTS)

Place Patient Label Here

Use this application for clients under the age of 19 years old.

BC Home Parenteral and Enteral Nutrition Programs 1081 Burrard Street, Vancouver, BC V6Z 1Y6	**Phone:** 604-806-9353	**Fax:** 604-806-8044
This application form must be completed in full and faxed to 604-806-8044 with all required documents. Please contact the HEN Coordinator at 604-806-9808 if you have questions about the application.		

Date of Application: ______________________________

Answers to the following questions must be provided for applications to be considered.

DOES YOUR PATIENT MEET THE FOLLOWING CIRTERIA FOR THE PROGRAM?		
CRITERION 1 – Disease requiring elemental / semi-elemental formula*	☐ Yes	☐ No
Does the patient have a disease requiring a semi-elemental/elemental product	☐ Yes	☐ No
If yes, which disease: ______________________________		
If no, provide the rationale for the use of a semi-elemental /elemental product: ______________________________		
Has there been demonstrated tolerance and efficacy of the formula for at least 14 days prior to application	☐ Yes	☐ No
CRITERION 2 – Pediatric Crohn's Disease (Exclusive Enteral Nutrition or Impaired / Risk of Impaired Growth	☐ Yes	☐ No

*Please note: Effective October 1, 2019 patients with cows milk protein intolerance (CMPI) will no longer be eligible for HEN funding. Please see the HEN website (www.bchomenutrition.org) for further information.

REFERRING PROVIDER INFORMATION		
Name:	Specialty:	Billing number:
Office phone:	Office fax:	Office email:
Signature:		
DIETITIAN (IF APPLICABLE)		
Name:	Specialty:	College ID number:
Office phone:	Office fax:	Office email:
PATIENT INFORMATION (please print clearly)		
Last name:	First name:	Middle name:
Date of birth: (dd/mmm/yyyy)	PHN:	Gender ☐ Male ☐ Female ☐ Non-binary ☐ Other: ______________
Address:		

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Delivery address: (if different than above) **(please note: a PO box cannot be used for deliveries)**		
Patient phone:	Alternate phone:	Email: Permission to email Patient: ☐ Yes ☐ No
Alternate contact person:	Relationship to patient:	Phone:
Primary Diagnosis:		
Medical Summary: (Attach any relevant medical consult notes or reports)		
Medications:		
Height: (cm)	Weight: (kg)	Date measured: (dd/mmm/yyyy)
Total estimated energy requirements (kcal/day):		

CURRENT NUTRITION TREATMENT: Please attach enteral feeding supply list (if applicable). Please note that the HEN program does not provide enteral feeding pumps.	
Access:	☐ Naso-gastric ☐ Naso-jejunal ☐ PEG ☐ PEG-J ☐ Oral
Routine:	
Feeding schedule:	☐ Nocturnal ☐ Intermittent ☐ Continuous
Administration method:	☐ Pump ☐ Gravity ☐ Oral
Formula:	
Formula concentration:	
Daily dosage: (cans/bottles)	
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/ Parent Guardian 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 ☐ Not approved: Reason: ______
Signature: ______ Date: ______