Providence Health Care | Provincial Health Services Authority | BC Children's Hospital

BC HOME ENTERAL NUTRITION (HEN) PROGRAM RENEWAL OR FORMULA CHANGE (PEDIATRIC PATIENTS)

11836

Place Patient Label Here

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.

☐ Application Renewal ☐ Formula Change

Date of Application: _____

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: _____
Patient address:		
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)		

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Medications		
Height: (cm)	Weight: (kg)	Date measured: (dd/mmm/yyyy)
Total estimated energy requirements: (kcal/day)		
***Please attach enteral feeding supply list (if applicable). Note that the HEN program does not provide enteral feeding pumps**		
Formula:		
Formula Concentration:		
Daily Dosage: (cans/bottles)		
Anticipated treatment duration: **(approval will only be given for a maximum of 6 months)**		
Reason for renewal or change:		
Medical information updates:		

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: _____