TPN Referral Form

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
☐ Hospital Discharge Summary
☐ Most recent labs—we will need CBC, CMP, Phos, Mg, Prealbumin, and Triglycerides within the last 24-48 hours to dose

Patient Name:	DOB:	Patient Phone:
Allergies:	Height:	Weight:
Diagnosis and ICD-10:		

☐ **Burnham's Vital Care Pharmacist and Dietician to review medical records and labs and make parenteral nutrition therapy recommendations**

OR

Protein: _____ g/kg/day **Fluid volume**: _____ mL/kg/day **Calories**: _____ kcal/kg/day

Estimated Length of Need: ☐ indefinite ☐ _____ months ☐ _____ years

Is the patient eating? ☐ No ☐ Yes **Is the patient diabetic?** ☐ No ☐ Yes - If yes, are they insulin dependent? ☐ Yes ☐ No

Please indicate if any of the following apply to the patient:

☐ Recent trauma or sepsis ☐ Recent TBI ☐ CKD ☐ Hemodialysis ☐ Hepatic failure

Line Type: ☐ PIV ☐ Midline ☐ PICC ☐ Port ☐ Tunneled Catheter ☐ Other: _____

Supply Orders: ☐ Pharmacy to provide all equipment and supplies needed to complete therapy as prescribed

☐ May use Burnham's Vital Care flush and catheter maintenance protocol

Home Health: ☐ _____ ☐ Burnham's Vital Care to arrange Home Health

☐ Nursing to provide weekly catheter care, dressing changes, and lab draws as needed.

Labs Orders: ☐ Protocol: CBC, CMP, Phos, Mg, Prealbumin, and Triglycerides on admission, 72 hours after any formula changes, and weekly once stable ☐ Other: _____

☐ Pharmacist to manage labs and dosage

Additional Instructions:

Prescribing Physicianr Name:	Signature:	Date:
Physician who will follow patient at home (if different from above):		