Seracal™ Written Order

Phone: 888-639-2110
eFax: 866-869-9442
Email: orders@vytalapatientservices.com

Referral Date: _____
Clinic Contact: _____
Phone: _____ **Email:** _____

Patient Detail

☐ Information attached (growth charts/weight trends, clinical notes, LMN)

Name | Parent or Legal Guardian, where applicable | Allergies

DOB | ☐ M ☐ F Sex | Weight | ☐ lbs ☐ kg | Height | ☐ inches ☐ cm | Email | Phone

Street Address | City | State | Zip Code

Emergency contact | Relationship | Phone

Insurance Detail

☐ Information attached (including front & back of insurance cards)

Primary Plan Name | Subscriber Name | DOB:

ID #: | Group #: | Phone:

Secondary Plan Name | Subscriber Name | DOB:

ID #: | Group #: | Phone:

Prescriber Detail

Prescriber Name: _____ NPI: _____ License #: _____

Preferred Communication Method: ☐ Phone ☐ Fax ☐ Email Address: _____

Phone: _____ Fax: _____ Email: _____

Diagnosis (Select all that apply)

- ☐ E44.0 Protein-calorie malnutrition of mild and moderate degree
- ☐ E63.0 Essential fatty acid (EFA) deficiency
- ☐ E63.9 Unspecified nutrient deficiency
- ☐ E84.0 - Cystic fibrosis with pulmonary manifestations
- ☐ E84.9 - Cystic fibrosis, unspecified
- ☐ K58.0 -Irritable bowel syndrome with diarrhea
- ☐ K50.90 Crohn's disease
- ☐ K85.90 Acute pancreatitis without necrosis or infection, unspecified
- ☐ K86.1 Other chronic pancreatitis
- ☐ K86.81 Exocrine pancreatic insufficiency
- ☐ K90.0 - Celiac disease
- ☐ K90.829 Short bowel syndrome
- ☐ K90.89 Other Intestinal malabsorption
- ☐ R62.51 Failure to thrive (child)
- ☐ R62.7 Failure to thrive (adult)
- ☐ C25.9 Malignant neoplasm of pancreas
- ☐ Other: _____

Order

Application: ☐ Oral ☐ Tube Feeding

Dispense Seracal™ 202 gram package (15 doses) at amount indicated to right. 1 dose is 13.4g.

Refill up to 12 times for 1 year.

	Patient Age	Servings per Day	Packages per Month
☐	<12 years	2 (13.4g) servings daily	4
☐	≥12 years	3 (13.4g) servings daily	6
☐		_____ servings daily	___ total packages/month

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. Pentec Health may contact this patient for purposes of completing the referral process.

_____ Date: _____
Digital Prescriber Signature