

Seracal™ Written Order



Phone: 888-639-2110
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Email: orders@vytalapatientsservices.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 _____ Sex F _____	Weight _____	lbs kg _____	Height _____	inches cm _____
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 | K50.90 Crohn's disease | K90.829 Short bowel syndrome |
| E63.0 Essential fatty acid (EFA) deficiency | K85.90 Acute pancreatitis without necrosis or infection, unspecified | K90.89 Other Intestinal malabsorption |
| E63.9 Unspecified nutrient deficiency | K86.1 Other chronic pancreatitis | R62.51 Failure to thrive (child) |
| E84.0 - Cystic fibrosis with pulmonary manifestations | K86.81 Exocrine pancreatic insufficiency | R62.7 Failure to thrive (adult) |
| E84.9 - Cystic fibrosis, unspecified | K90.0 - Celiac disease | C25.9 Malignant neoplasm of pancreas |
| K58.0 -Irritable bowel syndrome with diarrhea | | Other: _____ |

Order

Application: Oral Tube Feeding	Patient Age	Servings per Day	Packages per Month
Dispense Seracal™ 202 gram package (15 doses) at amount indicated to right. 1 dose is 13.4g.	<12 years	2 (13.4g) servings daily	4
	≥12 years	3 (13.4g) servings daily	6
Refill up to 12 times for 1 year.		_____ 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

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