



4 Creek Parkway Suite A · Boothwyn, PA 19061
Toll Free: (800) 223 4376 Fax: (800) 355 1029

Date of Referral ___/___/___

Contact Email _____

Referral Type: IDPN IPN

Malnutrition Type:

- Protein
- Calorie
- Protein / Calorie

Formula Choice:

- Proplete
- Proplete Plus Standard
- Proplete Plus CHO Control
- Proplete IPN

IDPN Only Dialysis Regimen (Check one): M/W/F T/Th/S Time: ___ am / ___ pm

Length of Treatment Time 2.75 to 3 Hours 3.25 to 3.50 hours 3.75 to 4 hours

IPN Only (Check two): Baxter Fresenius CAPD CCPD

Patient Name: _____ Physician Name: _____

Dialysis Unit: _____ Contact Name: _____

Unit Address: _____ Phone: _____

Allergies: _____ Fax: _____

Instructions

1. Complete Step #1 and Step #2 (if indicated).
2. Please Fax this Form with Requested Items in STEP #1 to: **800-355-1029** or **610-494-6148**

STEP# 1 Please Obtain & Provide The Required Items Below And Return With This Form.

- Face Sheet
- Routine Monthly Composite Lab Work (Current Month & Previous 2 Months)
- Supplements Trialed (Dates & Length of Trial) _____
- History & Physical
- Height _____ Weight _____ lbs/kgs IBW/DBW _____ lbs/kgs
- Weight Loss _____ lbs/kgs over _____ Month(s) **OR** % of Weight Loss over 3 Months _____ 6 Months _____
- Date of First Dialysis Treatment ___/___/___
- Copy of Insurance Card (**front & back**)
- Other Diagnosis _____
- Patient Personal Information Male Female

If not on Face Sheet please provide:

Address _____ Phone Number _____

If applicable please provide: Nursing Home Information

Name _____ Phone Number _____

Address _____ Admit Date _____

STEP# 2 * First Time Referrals Only

Physician Name _____ Phone Number _____

Physician Address _____ NPI # _____

_____ DEA # _____

*** First Time Referrals Only = First Referral for IDPN or IPN from the Specific Nephrologist**

A Pentec Health Intake Coordinator will notify the Unit Coordinator upon coverage determination.

You will be contacted if further information is required