State of Illinois
Department of Healthcare and Family Services

# Questionnaire for Enteral Nutrition

☐ Initial Certification ☐ Recertification ☐ Change in Prescription

**1. Participant Information:**

Participant Name _____ RIN _____ Birth Date _____

**2. Participant General Condition:**

Estimated Duration of Need for Enteral Nutrition: Months _____ Years _____ Lifetime _____

Height: _____ Weight: _____ Body Mass Index _____

Growth % (if child, provide growth chart) _____ Weight Loss (last 6 months) _____

**3. Enteral Nutrition:**

Product: _____ cans/day _____ calories/day _____

Product: _____ cans/day _____ calories/day _____

Product: _____ cans/day _____ calories/day _____

Total Cal/Day _____ Total Cal/Day Enteral _____ Total Cal/Day Non-Enteral _____

Please specify type of non-enteral nutrition (i.e. parenteral, oral):

Frequency Fed: _____

Administration Technique: NG Tube ☐ Gastrostomy ☐ Jejunostomy ☐ Oral (if oral,complete section 4) ☐

Method of Administration: Syringe ☐ Gravity ☐ Pump ☐

**4. Clinical Assessment (to be filled out if participant is taking supplement orally):**

Please provide a copy of the last clinical note addressing the diagnosis supporting nutritional deficiency, what attempts of diet modification have been made and why the diet modification failed.

Is the participant able to tolerate liquefied or pureed foods? Yes ☐ No (if no, provide clinical documentation) ☐

Is it possible to implement standard diet modifications for this participant? Yes ☐
No (if no, provide clinical documentation) ☐

Date that participant was last seen by the ordering physician _____

Is participant being seen by a dietician? Yes ☐ No ☐
(If Yes, please provide clinical documentation from most recent visit)

Albumin level _____ Date _____

Please provide documentation of any functional impairment to the alimentary tract and documentation of any labs indicative of malnutrition (i.e. albumin, pre-albumin, and transferrin)

Does this participant have ESRD? Yes ☐ No ☐

**5. WIC Eligible (if less than 5 years of age):**

Please attach a current WIC letter indicating status.

Is participant WIC eligible? Yes ☐ No ☐

If yes, how many cans/month received from WIC _____

**6. Certification:**

Practitioner's Signature _____ with Degree _____

Supervising or Collaborating Physician If Signing Practitioner Is Not an M.D. or D.O.:

NPI _____ Date _____ Office Phone # _____ Fax _____

(Area code first for both numbers)