



### TUBE FEEDING ORDER SHEET

CAMPER NAME \_\_\_\_\_

<p><b>Tube Feeding/Nutrient:</b> _____</p> <p><b>Enteral Feeding via:</b>    <b>Deliver feedings by:</b></p> <p><input type="checkbox"/> G-tube                      <input type="checkbox"/> Pump or <input type="checkbox"/> Gravity</p> <p><input type="checkbox"/> J-tube                        <input type="checkbox"/> Bolus or <input type="checkbox"/> Continuous</p> <p><input type="checkbox"/> PEG tube</p> <p><b>For Bolus delivery:</b> _____ ml _____ times per day (or q _____ hours)</p> <p><b>For Continuous delivery:</b> _____ ml per hour, _____ hours a day. Usual time: _____</p> <p><b>Downtime:</b></p> <p>_____ <input type="checkbox"/> AM <input type="checkbox"/> PM to _____ <input type="checkbox"/> AM <input type="checkbox"/> PM</p> <p><input type="checkbox"/> None</p> <p>Total Nutrient _____ ml/24 hours.</p> <p>Total Calories _____ Cal/24 hours</p> <p>Flush tube with _____ ml of water q _____ hours</p> <p>Total volume of nutrient + flush= _____ ml/24 hours</p> <p>Flush tube with _____ ml of water before and after each medication pass.</p> <p><input type="checkbox"/> Flush tube with 5ml of water between each medication.</p>	<p><b>Residual:</b></p> <p>Check for residual q _____ hours.</p> <p>If _____ ml or over, hold feeding for _____ hours then resume feeding and recheck residual in _____ hours <b>OR</b> hold feeding until residual less than _____ ml.</p> <p>If residual _____ ml or over, notify MD.</p> <p><b>Placement:</b></p> <p>Check tube for proper placement:</p> <p><input type="checkbox"/> Prior to each feeding</p> <p><input type="checkbox"/> Prior to flush</p> <p><input type="checkbox"/> Prior to medication administration</p> <p><b>Elevate head of bed:</b></p> <p>_____ degrees during feeding and for _____ hours after feeding complete</p> <p><input type="checkbox"/> Constantly at _____ degrees.</p> <p><input type="checkbox"/> Not applicable</p> <p><b>Tube:</b></p> <p>Change feeding set (spike, cap, bag) q _____</p> <p>Change syringe q _____</p> <p>Change Y-connector q _____</p> <p>Tube Size: _____</p> <p>Balloon inflation _____ ml</p>
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\*\*\*PLEASE COMPLETE OTHER SIDE\*\*\*





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Specific directions/orders not included on previous side of form:

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Site care: \_\_\_\_\_  
\_\_\_\_\_

Camp RN may replace tube PRN if dislodged or clogged – Replacement tube change supplies must be sent with camper

Initial placement of tube: \_\_\_\_\_

Date of last tube change: \_\_\_\_\_

**\*\*\*CAMPERS ARE REQUIRED TO PROVIDE ALL TUBE FEEDING SUPPLIES: NUTRIENT FORMULA, PUMP, TUBING, SYRINGES, DRESSINGS, AND REPLACEMENT FEEDING TUBE IF APPLICABLE THAT WILL BE NEEDED DURING THE CAMP WEEK.\*\*\***

►Physician Stamp

►Physician Signature (Original physician signature required)

Date:

