

Enteral Feed Order Form

Section 1: Patient Demographics		
Name:	Date:	
Address:	BRN:	
City: Postal Code:	Phone:	
Section 2: Tube Details		
Type of Tube:	Date of Insertion:	
<input type="checkbox"/> Nasogastric	Physician who inserted the Tube:	
<input type="checkbox"/> Percutaneous Endoscopic Gastrostomy (PEG)	Plan for Tube Replacement:	
<input type="checkbox"/> Percutaneous Endoscopic Gastrojejunostomy (PEG-J)		
<input type="checkbox"/> Jejunostomy		
Section 3: Formula Prescription		
Name of Formula:	Daily Amount: (ml)	
Current Feeding Rate: for Hours		
Goal Feeding Rate: for Hours		
<input type="checkbox"/> Community RD to Progress according to Tolerance and BPG OR <input type="checkbox"/> Special Instruction for Feeding Rates:		
Gravity or Pump:		
* Note: A signed prescription for feed including type and rate, as well as a completed Nutrition Products Form from the physician must be faxed to the pharmacy providing the feed.		
Pharmacy RX sent to:		
Section 4: Flushing Requirements		
Flushing Requirements:		
Oral Intake Restrictions / Requirements:		
Additional Information:		
Section 5: Equipment		
NOTE: SW LHIN provides short term rental up to 30 days. Patient must be informed of this on admission and confirm completion of Assisted Devices Application.		
Item - Portable Pump: <input type="checkbox"/> Portable Joey (Code 4104)		
Section 6: Enteral Feed Supplies		
Closed System	Open System – Order 1q 3 days	
<input type="checkbox"/> Joey Spike Set & Tubing – No Bag (Code 4009) 7/week	<input type="checkbox"/> Joey Gravity Feed Bag & Tubing 1000ml (Code 4104) 3/week	
Section 7: Miscellaneous Supplies		
<input type="checkbox"/> Item: Y Extension Tubing	Code: 9302	7/Week Max
<input type="checkbox"/> Extension Tubing 4"	Code: 4003	7/Week Max
<input type="checkbox"/> Syringe 60cc L.L	Code: 5608	15/Week Max
<input type="checkbox"/> Syringe 60cc C.T	Code: 5602	15/Week Max
Other:		