HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

Enteral Feed Order Form

Section 1: Patient Demographics

Name: Address: City: Postal Code:	Date: BRN: Phone:

Section 2: Tube Details

Type of Tube: ☐ Nasogastric ☐ Percutaneous Endoscopic Gastrostomy (PEG) ☐ Percutaneous Endoscopic Gastrojejunostomy (PEG-J) ☐ Jejunostomy	Date of Insertion: Physician who inserted the Tube: Plan for Tube Replacement:

Section 3: Formula Prescription

Name of Formula: Daily Amount: (ml)
Current Feeding Rate: for Hours
Goal Feeding Rate: for Hours
☐ Community RD to Progress according to Tolerance and BPG **OR** ☐ 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: South West HCCSS provides short term rental up to 60 days. Patient must be informed of this on admission and confirm completion of Assisted Devices Application.

Item - Portable Pump: ☐ Portable Joey *(Code 4104)*

Section 6: Enteral Feed Supplies

Closed System	**Gravity System** (no pump)	**Open System** – Order 1q 3 days
☐ Joey Spike Set & Tubing – No Bag (*Code 4009) 7/week*	☐ Feed Bag Gravity Set 1000ml (*Code 4101) 3/week*	☐ Joey Gravity Feed Bag & Tubing 1000ml (*Code 4104) 3/week*

Section 7: Miscellaneous Supplies

☐ Item: Y Extension Tubing	Code: 9302	7/Week Max
☐ Extension Tubing 4”	Code: 4003	7/Week Max
☐ Syringe 60cc L.L	Code: 5608	15/Week Max
☐ Syringe 60cc C.T	Code: 5602	15/Week Max
☐ Syringe ENFIT 60cc	Code: 4013	7/week Max
☐ Y Extension Tubing ENFIT	Code: 4014	7/week Max
☐ Other:		