

## Enteral Feeding Order Form - Adult

PATIENT DETAILS		
Surname		First Name
Home Address		
City		Postal Code
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)

ENTERAL FEEDING TUBE DETAILS		
Type of Feeding Tube		
<input type="radio"/> Nasogastric (NG tube) <input type="radio"/> Gastrostomy (G-tube) <input type="radio"/> Gastrojejunostomy (GJ-tube)		
<input type="radio"/> Percutaneous Endoscopic Gastrostomy (PEG) <input type="radio"/> Combination G/GJ tube		
<input type="radio"/> Percutaneous Endoscopic Gastrojejunostomy (PEG-J) <input type="radio"/> Jejunostomy (J-tube)		
<input type="radio"/> Other:		
Date of Insertion (YYYY-Month-DD)	Tube Size	Name of Provider Performing Tube Insertion
Plan for Tube Replacement		

FORMULA PRESCRIPTION	
Name of Formula	Daily Amount (mL)
Current Feeding Rate _____ cc/hr for _____ hrs	Goal Feeding Rate _____ cc/hr for _____ hrs
Feeding Progression Instructions	
<input type="radio"/> Community Registered Dietitian to progress according to tolerance and Best Practice Guidelines	
<input type="radio"/> Follow special instructions for feeding rates (please specify below)	
Special Instructions	
Gravity or Pump	
<b>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.</b>	
Pharmacy Prescription sent to (Name)	

FLUSHING AND ORAL INTAKE REQUIREMENTS
Flushing Requirements
Oral Intake Restrictions/Recommendations
Additional Information

Surname:	First Name:	HCN:
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## SUPPLIES

Assistive Devices Program Application initiated by (Name)	Date Submitted (YYYY-Month-DD)
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### ENTERAL FEED PUMP/SETS

<input type="checkbox"/> Portable Joey pump	(Code 9305)	
Closed System		
<input type="checkbox"/> Joey Spike Set & Tubing – No Bag	(Code 4009)	7/week
Gravity System (no pump)		
<input type="checkbox"/> Feed Bag Gravity Set 1000ml	(Code 4101)	3/week
Open System (order 1 time every 3 days)		
<input type="checkbox"/> Joey 1000ml Feed Bag & Tubing	(Code 4104)	3/week

### OTHER SUPPLIES

<input type="checkbox"/> Silicone tape	(Code 6811)	
<input type="checkbox"/> Intravenous infusion (IV) pole	(Code 8910)	
<u>Legacy Enteral Feeding Supplies</u>		
<input type="checkbox"/> Syringe 50cc Catheter Tip	(Code 5602)	7/week max
<input type="checkbox"/> Syringe 50cc Luer Lock	(Code 5608)	7/week max
<input type="checkbox"/> Syringe 10cc Luer Lock	(Code 5606)	7/week max
<input type="checkbox"/> Syringe 10cc Slip Tip	(Code 5601)	7/week max
<input type="checkbox"/> Y extension tubing	(Code 9302)	2/week max
<input type="checkbox"/> Extension tubing 4 ft.	(Code 4003)	7/week max
<u>ENFit Supplies</u>		
<input type="checkbox"/> ENFit Syringe 60cc	(Code 4025)	7/week max
<input type="checkbox"/> ENFit Syringe 12cc	(Code 4022)	7/week max
<input type="checkbox"/> ENFit Transfer straw	(Code 4015)	7/week max
<input type="checkbox"/> ENFit White stepped adaptor	(Code 4016)	2/week max
<input type="checkbox"/> ENFit Y extension tubing	(Code 4014)	7/week max
<input type="checkbox"/> ENFit Extension tubing 4 ft.	(Code 4018)	7/week max
<input type="checkbox"/> Additional Supplies:		

## DECLARATION

_____ Dietitian Name	_____ Signature	_____ Date Signed (YYYY-Month-DD)
_____ Physician/Nurse Practitioner Name (CPSO or CNO #)	_____ Signature	_____ Date Signed (YYYY-Month-DD)