Stark County Board of Developmental Disabilities

Tube Feeding Orders

Individual's Name: _____ **Date of Birth:** _____

Address: _____

Phone: _____ **Physician:** _____

I acknowledge that the above named individual will be attending a center-based program and will require g/j-tube feedings during program hours.

Please Specify:

Type of device: ☐ Gastrostomy (foley) Size _____ ☐ Peg Size _____

☐ Jejunostomy Size _____ ☐ Mic-Key Size _____

Type of Formula: _____

Time _____ Amount _____ Rate _____

Method of Administration:
- ☐ infusion pump
- ☐ continuous
- ☐ bolus

Flush**:** **Solution** _____ **Amount** _____ **Frequency** _____

Patient is
- ☐ NPO at all times
- ☐ may receive fluids by mouth
- ☐ may receive oral feeding
- ☐ may participate in swimming classes

Please specify consistency, texture and any special instruction for any oral feeding.

_____

_____

_____

Starting Date: _____ **Termination Date**:_____

_____/ _____ **NPI #** _____

Physician's Name (Print) **Signature (No Stamps)**

Date _____ Office Phone Number _____

==========

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give the personnel of the Stark County Board of DD permission to administer the above G/J-Tube feeding to me/my son/daughter.

_____ _____ _____ _____

Individual's Signature Date Parent/Guardian Signature Date