CAMP MILLHOUSE
TUBE FEEDING ORDER SHEET

Name: (First) (Last)
_____

WEIGHT _____ HEIGHT _____

Enteral Feeding due to: (Diagnosis)

_____

Allergies (include past reaction)

_____

Tube Feeding: (nutrient)

_____

ORDERS

Enteral Feeding via:
☐ G-tube
☐ J-tube
☐ PEG tube

Deliver feedings by:
☐ Pump or ☐ Gravity
☐ Bolus or ☐ Continuous

For Bolus delivery: _____ ml _____ times per day (or q _____ hours)

For Continuous delivery: _____ ml per hour, _____ hours a day. Usual time: _____
Downtime:
_____ ☐AM ☐PM to _____☐AM ☐PM
☐ None

Total Nutrient _____ ml/24 hours.
Total Calories _____Cal/24 hours

Flush tube with _____ ml of water q _____ hours

Total volume of nutrient + flush= _____ ml/24 hours

Flush tube with _____ ml of water before and after each medication pass.

☐ Flush tube with 5ml of water between each medication.

Residual:
Check for residual q _____ hours.

If _____ ml or over, hold feeding for _____ hours then resume feeding and recheck residual in ___hours **OR** hold feeding until residual less than _____ml.

If residual _____ ml or over, notify MD.

Placement:
Check tube for proper placement:
☐ Prior to each feeding
☐ Prior to flush
☐ Prior to medication administration

Elevate head of bed:
_____ degrees during feeding and for _____ hours after feeding complete
☐ Constantly at ___ degrees.
☐ Not applicable

Tube:
Change feeding set (spike, cap, bag) q _____
Change syringe q _____
Change Y-connector q _____
Tube Size: _____
Balloon inflation _____ml

***** Please complete other side *****

ADDITIONAL ORDERS/COMMENTS

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

_____

_____

_____

_____

_____

_____

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: