Physician/Hospital/Clinic Orders for Gastrostomy Tube/Button Feed

Trumbull County Board of Developmental Disabilities - Fairhaven Programs
45 North Road, Niles, Ohio 44446

☐School-330-652-5811 Fax-330-652-5864 ☐Niles WS-330-544-0462 Fax-330-652-2743 ☐Champion WS-330-847-7275 Fax-330-847-6009 ☐Tony Tomaski Ctr.-330-652-6168 Fax-330-652-6190
☐Senior Center-330-652-1116 – Fax-330-652-1964

Name of Enrollee _____ Date _____

Address _____
Number Street City State Zip

Phone _____

Diagnosis _____

Allergies: List all _____

Procedure/Treatment Requested: ***G-Tube/Button Feeding at Fairhaven Program***

1. Type formula: _____
2. Amount to be given: _____
3. Time to be given: _____
4. Rate of feeding: _____
   a. gravity: _____
   b. pump: _____
5. Flush solution: _____
6. Amount of flush: _____
7. Residual checks: _____
8. Specific instructions: _____
9. change tubing Q: _____
10. Enrolle may: _____ may not _____ swim.
    COMMENTS: _____
11. Activity or position after feeding: _____
12. Care of G-tube site: _____

Oral – Feed Status

Please indicate all that apply:

_____ NPO at all times
_____ May receive oral stimulus consisting of face, mouth, throat massage/stretching; flavors to lips and tongue only.
_____ May receive fluids by mouth.
_____ May receive tastes of food.

Please specify what symptoms you want reported to you or any further instructions and/or limitations:

_____

_____

Physician's typed/printed name and phone #: _____

Physician's Signature: _____ Date: _____

FOR PARENT/GUARDIAN COMPLETION:

I request that these procedures as outlined be carried out at Fairhaven by the Nurse or designee.

Parent/Guardian Signatures: _____ Date: _____

_____ Date: _____