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

Trumbull County Board of Developmental Disabilities – Fairhaven School Program
420 Lincoln Way, Niles, Ohio 44446

School 330-652-5811 FAX 330-652-5864

It is recommended that whenever possible, medications and / or treatments be administered at home. When necessary medications and treatments shall be administered during program hours according to Board Policy and procedures **once signed permission has been submitted from the Physician and from the parent / guardian / provider:**

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: ____________