(place patient label here)

Patient Name:___________________________

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: ____

Allergies with reaction type:____

D/C HOME WITH ENTERAL FEEDING TUBE ON BOLUS TUBE FEEDINGS **Version 3 07/16/2010**

Diagnosis: ____

____

Anticipated length of need: ____

BOLUS TUBE FEEDING INFORMATION:

1. Formula: ____

   OK to substitute equivalent if above not available Y N ______________

2. Amount: ______ can(s) _______ml _______ times per day

3. Water Bolus: ______ can(s)______ ml water after each TF

Feeding Tube Care: Change dressing daily until directed otherwise by physician
Cleanse feeding tube site with ½ strength hydrogen peroxide daily for____days then cleanse site daily with soap and water or as directed by physician

1. Apply antibiotic ointment to skin exit site daily and cover with split drain dressing
2. Dispense ___2x2 or ___4x4 split drain dressings per month until dc'd.

BOLUS FEEDING Supplies: Dispense per month

1. ___ 60 ml Cath tip syringes
2. ___ Graduate pitcher
3. ___ Other (tape etc)____

HOME CARE REFERRAL: Y N

F/U tube feeding administration and teaching as indicated.

Provider Signature:____Date:__________Time:_________