

(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: _____

Enteral feeding-Adult

Version 3 1/27/2014

General

- Consider promotility agent if 2 consecutive residuals greater than 250 milliliter.
- Consider advancing tube below the ligament of Treitz if residual is consistently greater than 500 milliliter.

Nursing Orders

- Feeding tube insertion/management (DOBHOFF) for feeding delivery
- Nasogastric/orogastric tube insertion/management
- Gastric tube management (PEG)
- Jejunal tube management (PEJ)
- Elevate head of bed 30-45 degrees
- Measure gastric residual every four hours for continuous feeding or prior to each bolus feeding and document amount and return into patient unless volume is greater than 500 milliliter or greater than 250 milliliters for 2 consecutive checks
- If residual is less than 250 milliliter continue feeding and increase to goal rate
- Notify provider: if 2 consecutive residual are greater than 250 milliliter; discard residual and hold feeding
- Notify provider: if residual is greater than 500 milliliter; discard residual and hold feeding

Adult formula options:

- | | |
|---|---|
| <input type="checkbox"/> Fibersource HN (Replacing Jevity 1.2) | <input type="checkbox"/> Nutren 2.0 (Replacing TwoCal HN) |
| <input type="checkbox"/> Isosource 1.5 CAL (Replacing Jevity 1.5) | <input type="checkbox"/> Novasource Renal (Replacing Nepro) |
| <input type="checkbox"/> Isosource HN (Replacing Osmolite 1.2) | <input type="checkbox"/> Impact Peptide 1.5 (Replacing Oxepa) |
| <input type="checkbox"/> Replete Fiber (Replacing Promote With Fiber) | <input type="checkbox"/> Peptamen AF (Replacing Vital AF 1.2) |
| <input type="checkbox"/> Diabetisource AC (Replacing Glucerna 1.2) | <input type="checkbox"/> NutriHep |

Administration type:

Continuous feeding

- Initial rate: 20 milliliter/hour Initial rate: ____ milliliter/hour
- Increase by ____ milliliter/hour every ____ hours to goal rate of ____ milliliter/hour

Intermittent Bolus

- ____ milliliter every ____ hour

Continuous Nocturnal

- ____ milliliter per hour from ____ PM to ____ AM

Intermittent Daytime bolus with Continuous Nocturnal

- Bolus feed: ____ milliliter bolus at _____ (times) and Nocturnal feed: ____ milliliter per hour from ____ PM to ____ AM
- Bolus feed: if eats less than 50% of meal give ____ milliliter bolus after meal and Nocturnal feed: ____ milliliter per hour from ____ PM to ____ AM

Dietary Supplements and Free Water

Free Water

- ____ milliliter every ____ hours

Protein Powder (BENEPROTEIN)

- ____ scoop ____ x per day

Soluble Fiber (NUTRISOURCE FIBER) -Max 6 scoops per day

- ____ scoop ____ x per day

Radiology

Radiograph, kidney-ureter-bladder (KUB) , portable,

- routine for tube placement verification prior to beginning feeds

Consults

- Consult to dietitian, adult for assessment and recommendations

Provider Signature: _____ Date: _____ Time: _____