(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

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:_____

Pediatric-Enteral feeding

Version 2 12/19/2013

- This pediatric order set is suggested for use in patients 1 month through 17 years of age and less than 50 kilograms
- This order set should be used in conjunction with the pediatric admission or pediatric critical care admission order set if patient not already admitted

Nursing Orders

- ☐ Feeding tube insertion/management
- ☐ Gastric tube management
- ☑ Elevate head of bed 30-45 degrees
- ☑ Measure gastric residual before each bolus feeding and document amount.
- ☑ Measure gastric residual every 6 hours for continuous feeding and document amount.
- ☑ Notify provider: If residual is 30 milliliter in bolus feeding or if residual is greater than the total volume delivered in the previous 2 hours delivered in continuous feeding

Pediatric formula options:

Pediatric Enteral Feeding:

- ☐ Breast milk
- ☐ Enfamil 20 kcal/oz
- ☐ Prosobee
- ☐ Nutramigen
- ☐ Nutren Junior (Replacing Pediasure Enteral)
- ☐ Fibersource HN (Replacing Jevity 1.2)
- ☐ Pedialyte
- ☐ other _____

Administration type:

Gravity Bolus

- ☐ ____ milliliter ____ x per day

Bolus via infusion pump

- ☐ ____ milliliter over ____ minutes ____ x per day

Continuous feeding

- ☐ ___ milliliter/hour
- ☐ ___ milliliter/hour for ___ hours per day

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

Dietary Supplements and Water Flush

Water Flush

- ☐ _____ milliliter every ____ hours

Dietary supplements

- ☐ _____

Consults

- ☑ Consult to dietitian, pediatric for assessment and recommendation

Provider Signature:_____Date:_____Time:_____