(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:_____

D/C HOME WITH ENTERAL FEEDING TUBE AND TUBE FEEDINGS (PEDIATRIC) Version 4 04/22/2014

Diagnosis:_____
Method of tube feeding required: (Check One)
___Bolus ___ Gravity ____ Continuous per feeding pump
If unable to tolerate regular Bolus Feedings, reason why: _____
_____

_____

Anticipated length of need:_____

TUBE FEEDING INFORMATION:

1. Formula:_____
   OK to substitute if above not available Y N _____
2. ____Bolus _____ ml _____ times per day
3. ____Gravity _____ml over _____minutes _____times per day
4. ____Continuous _____ml per hour for _____hours per ____day ____night
5. Supplemental water _____ml water _____ times per day

FEEDING TUBE CARE: Change dressing daily until directed otherwise by hysician

1. 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.
2. Apply antibiotic ointment to skin exit site and cover with split drain dressing.
3. Dispense _____ 2x2 or _____ 4x4 split drain dressing per month until dc'd.

TUBE FEEDING SUPPLIES: Dispense per month.

1. _____Enteral graduates
2. _____60 ml cath tip syringes
3. _____Gravity Feeding bags or ___Pump feeding bags
4. _____Feeding pump with pole
5. _____Slip tip syringes for enteral administration of medications ___ ml Size
6. _____Extension tubings
7. _____Gastrostomy Kit: Change as directed. Keep emergency replacement on hand.
8. _____Other (tape etc) _____

HOME CARE REFERRAL: Y N

F/U tube feeding administration and teaching as indicated.

Provider Signature:_____Date:_____Time:_____