GREYSTAR
HEALTHCARE SERVICES LLC

PHYSICIAN ORDER FOR G-TUBE FEEDING

PATIENT'S NAME: _____ **DOB:** _____

ALLERGIES: _____ **TYPE OF FEEDING TUBE:** _____

THE TREATMENTS NEEDED ARE: (please indicate):

☐ **Feeding by Gravity** ☐ **Feeding by Pump**

☐ **G-tube Medications – Please list drug, dosage and frequency:** _____

_____

PROCEDURE FOR FEEDING ADMINISTRATION:

1. **POSITION PATIENT**
   - ☐ Sitting upright or semi-reclining with head at _____degree angle – OR –
   - ☐ Lying on right side with head elevated at_____degree angle – AND –
   - ☐ Remain elevated for _____minutes after feeding is administered
2. **ASPIRATE – Check one:**
   - ☐ I DO order to check for aspirate
     If aspirate is greater than _____cc, ☐ Feed ☐ DO NOT feed
     _____Delay feeding for (_____) minutes and repeat aspiration.
     ***If aspirate continues to be greater than _____, contact PCP or Call 911.
3. **FLUSHING – Check one:**
   - ☐ I DO order G-tube to be flushed ☐ Before feeding or medications with _____cc of free water
     ☐ After feeding or medications with _____cc of free water
   - ☐ I DO NOT order G-tube to be flushed
4. **PLEASE SPECIFY DIET - that will be given during school day:**
   - ☐ TYPE OF FEEDING: _____ Amount: _____
     Frequency of feedings during the day: _____
   - ☐ It is ok for parent/guardian to direct changes in frequency/amount/ times of feedings
   - ☐ Please give _____of free water at (indicate time)_____AM and/or _____PM
5. **DIRECTIONS FOR DISLODGED G-TUBE:** _____
   _____
6. **COMMENTS:** _____
   _____

_____ _____

Physician's Signature **Date**

_____ _____

Physician's Name (printed) **Telephone Number**