HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Sud-Ouest

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

Enteral Feeding Order Form - Adult

PATIENT DETAILS

Surname		First Name
Home Address		
City		Postal Code
Health Card Number (HCN)	Version Code	Date of Birth (YYYY-Month-DD)

ENTERAL FEEDING TUBE DETAILS

Type of Feeding Tube

- ◯ Nasogastric (NG tube)
- ◯ Gastrostomy (G-tube)
- ◯ Gastrojejunostomy (GJ-tube)
- ◯ Percutaneous Endoscopic Gastrostomy (PEG)
- ◯ Combination G/GJ tube
- ◯ Percutaneous Endoscopic Gastrojejunostomy (PEG-J)
- ◯ Jejunostomy (J-tube)
- ◯ Other:

Date of Insertion (YYYY-Month-DD)	Tube Size	Name of Provider Performing Tube Insertion
Plan for Tube Replacement		

FORMULA PRESCRIPTION

Name of Formula	Daily Amount (mL)
Current Feeding Rate _____ cc/hr for _____ hrs	Goal Feeding Rate _____ cc/hr for _____ hrs

Feeding Progression Instructions

- ◯ Community Registered Dietitian to progress according to tolerance and Best Practice Guidelines
- ◯ Follow special instructions for feeding rates (please specify below)

Special Instructions

Gravity or Pump

Note: A signed prescription for feed including type and rate, as well as a completed Nutrition Products Form from the physician must be faxed to the pharmacy providing the feed.

Pharmacy Prescription sent to (Name)

FLUSHING AND ORAL INTAKE REQUIREMENTS

Flushing Requirements

Oral Intake Restrictions/Recommendations

Additional Information

Ontario

Surname:	First Name:	HCN:

SUPPLIES

Assistive Devices Program Application initiated by (Name)	Date Submitted (YYYY-Month-DD)

ENTERAL FEED PUMP/SETS

☐ Portable Joey pump	*(Code 9305)*	
Closed System		
☐ Joey Spike Set & Tubing – No Bag	*(Code 4009)*	*7/week*
Gravity System (no pump)		
☐ Feed Bag Gravity Set 1000ml	*(Code 4101)*	*3/week*
Open System (order 1 time every 3 days)		
☐ Joey 1000ml Feed Bag & Tubing	*(Code 4104)*	*3/week*

OTHER SUPPLIES

☐ Silicone tape	*(Code 6811)*	
☐ Intravenous infusion (IV) pole	*(Code 8910)*	
<u>Legacy Enteral Feeding Supplies</u>		
☐ Syringe 50cc Catheter Tip	*(Code 5602)*	*7/week max*
☐ Syringe 50cc Luer Lock	*(Code 5608)*	*7/week max*
☐ Syringe 10cc Luer Lock	*(Code 5606)*	*7/week max*
☐ Syringe 10cc Slip Tip	*(Code 5601)*	*7/week max*
☐ Y extension tubing	*(Code 9302)*	*2/week max*
☐ Extension tubing 4 ft.	*(Code 4003)*	*7/week max*
<u>ENFit Supplies</u>		
☐ ENFit Syringe 60cc	*(Code 4025)*	*7/week max*
☐ ENFit Syringe 12cc	*(Code 4022)*	*7/week max*
☐ ENFit Transfer straw	*(Code 4015)*	*7/week max*
☐ ENFit White stepped adaptor	*(Code 4016)*	*2/week max*
☐ ENFit Y extension tubing	*(Code 4014)*	*7/week max*
☐ ENFit Extension tubing 4 ft.	*(Code 4018)*	*7/week max*

☐ Additional Supplies:

DECLARATION

Dietitian Name	Signature	Date Signed (YYYY-Month-DD)
Physician/Nurse Practitioner Name (CPSO or CNO #)	Signature	Date Signed (YYYY-Month-DD)