PHYSICIAN/HOSPITAL/CLINIC ORDERS FOR GASTROSTOMY TUBE/BUTTON FEED

**Trumbull County Board of Developmental Disabilities – Fairhaven School Program**
**420 Lincoln Way, Niles, OH 44446**

**Phone: 330-652-5811 Fax – Nurse's Office: 330-574-4517**

It is recommended that whenever possible, medications and/or treatments be administered at home. When necessary, medications and treatments shall be administered during program hours according to Board Policy and procedures ***once signed permission has been submitted from the Physician and from the parent/guardian/provider:***

Name of Enrollee: _____ DOB: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: _____

Diagnosis: _____

Allergies *(List All)*: _____

**Procedure/Treatment Requested:** G-Tube/Button Feeding at Fairhaven Program

1. Type formula: _____
2. Amount to be given: _____ Time to be given: _____
3. Rate of feeding: _____ ❑ Gravity _____ ❑ Pump_____
4. Flush solution: _____
5. Amount of flush: _____
6. Residual checks: _____
7. Specific instructions: _____
8. Change tubing Q: _____
9. Enrollee ❑ may or ❑ may not swim. Comments: _____
10. Activity or position after feeding: _____
11. Care of G-tube site: _____

ORAL-FEED STATUS

**THIS SECTION MUST BE FILLED OUT**

Please indicate all that apply and please specify texture and consistency of oral food and fluid:

- ❑ NPO at all times. Comments: _____
- ❑ May receive oral stimulus consisting of face, mouth, throat massage/stretching; flavors to lips and tongue only. Comments: _____
- ❑ May receive fluids by mouth. Comments: _____
- ❑ May receive tastes of food. Comments: _____

Please specify what symptoms you want reported to you or any further instructions and/or limitations:

_____

Physician's Typed/Printed Name & Phone: _____

Physician's Signature: _____ Date: _____

**For Parent/Guardian Completion:**

I request that these procedures as outlined be carried out at Fairhaven by the Nurse or designee.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____