Lexington County School District One

Enteral Feeding
Physician Orders

School Year:______________________

Student Name	DOB	Grade	School

Diagnosis:	ICD-10 Code:

Type of Feeding Port:	Tube Size:

Type of feeding: Gravity □ Pump (bolus) □ Pump (continuous) □	Name of Formula:	Amount to be given:	Frequency:
Flush:(type) Flush before, amount:____________ Flush after, amount:____________ Additional:__________	Check for residuals: Yes □ Time:__________ No □ Hold feeding for Hold tube feeding for __________hour/hours. May restart feeding when residual is_______.	Is the student NPO? Yes □ No □ Liquids Yes □ No □ Amount __________________ Thickening Yes □ No □	Is suctioning needed for this student? Yes □ No □ Suctioning type:_________ __________________ Suctioning frequency:
Additional Oral Feedings Yes□ No□ Amount __________________ Texture	Does the tube need to be burped/ left open to air post feeding? Yes □ No □ If Yes, for how long?	Additional instructions for suctioning __________________ __________________	Additional instructions for ostomy care

Reinsert tube for dislodgement? Yes □ No □ Instructions for dislodgement and when to contact physician:

____

____

____

By signing this form, the parent/guardian and health care practitioner acknowledge that information provided on this form may be included in the student's Individual Healthcare Plan.

Health Care Practitioner Name ____**Date**____________________

Health Care Practitioner Signature____

Phone______________________**Office Nurse's Name/ other contact for questions** ______________________

Parent/Guardian Name____**Date**____________________

Parent/Guardian Signature____

Phone (home)________________________**(work)**______________________**(cell)**______________________