RELEASE FOR GASTROSTOMY TUBE/BUTTON FEEDING

Enrollee: ______________________________________ Date of Birth: ____________________

Address: ____
Number Street City State Zip

Diagnosis: ____

Effective date of order to Start: ________________________ Stop: ________________________

Procedure/Treatment Requested: **G-TUBE/BUTTON FEEDING AT FACILITY**

1. Type formula: ____
2. Amount to be given: ____
3. Time to be given: ____
4. Enrollee may ☐ may not ☐ swim.

Comments: ____

ORAL-FEED STATUS

Please indicate all that apply:

________ NPO (nothing by mouth) at all times.

________ May receive oral stimulus consisting of flavors to lips and tongue only.

________ May receive fluids by mouth.

________ May receive tastes of food.

Please specify any further instructions: ____

Licensed Health Professional's Printed Name/Address/Phone: ______________________________

____

Licensed Health Professional's Signature: ________________________ Date: ________________

FOR PARENT/GUARDIAN COMPLETION

I request that these procedures, as outlined, be carried out at the facility by the nurse/delegated staff.

Parent/Guardian Signatures: ____________________________________ Date: ________________

____________________________________ Date: ________________

Nurse Signature: ____ Date: ________________