Duke HomeCare & Hospice

# Enteral Order Form

**Patient Name:_____ DOB:_____**

| |
|---|
| **Formula name:** |
| **Device:**<br>☐ **NG tube: ___ Fr x ___ cm**<br>☐ **ND tube**<br>☐ **NJ tube**<br>☐ **J tube**<br>☐ **GJ tube**<br>☐ **PEG/G-tube**<br>☐ **Mic-Key Button: __ Fr x ___ cm**<br>☐ **AMT Mini One Button: ___ Fr x ___ cm** |
| **Route:**<br>☐ **Infinity pump**<br>☐ **Gravity**<br>☐ **Bolus**<br>☐ **PO (NC Medicaid Only)** |
| **Feeding order/Nutrition recommendations (Rate or Dose/Frequency):** |
| **Expected date of facility discharge:** |
| **Additional needs** *(wound care, PT, OT, ST, etc)***:** |

- ✓ Attach discharge summary / available medical notes and RD notes

**Provider Name (Print): _____**

**Provider Signature:_____ Date:_____**