



Division of Developmental Disabilities Services
Community Services

Nursing Enteral Tube Form

Service Recipient: _____ MCI Number: _____

Healthcare Provider: _____ Date of Tube Placement: _____

Reason for Placement: _____

Enteral Tube Information:

G-tube or J-tube: _____ Type of Tube: _____

Amount of Water in Balloon: _____ Size of Tube: _____

Enteral Tube Utilized for (check all that apply): Feedings Hydration Medications

Other Information: _____

Feeding Bag/Container Information:

Type of Feeding Bag/Container: _____ How Often Changed: _____

Equipment Needed to Hang Feeding Bag/Container: _____

Feeding Pump Information:

Pump Type: _____

If Pump Malfunctions Contact: _____

Cleaning Instructions: _____

Enteral Tube Routine Changes/Replacement:

How Often is Tube Changed: _____ Who Changes: _____

Special Instructions for Tube Changes: _____

Who Consents for Tube Changes: _____ Number: _____

Who to Contact in Case of Emergency Related to the Enteral Tube and/or Enteral Tube Needs to be Replaced: _____

Other Equipment Used: NO YES **(If YES Continue)**

Name of Equipment: _____

How Often Cleaned: _____

How Cleaned: _____

Other: _____

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Enteral Tube Supplies are Purchased/Obtained From: _____

Positioning During Tube Feedings/Hydration/Medications: _____

Special Information/Instructions You Need to Know for Medication Administration: _____

Potential Problems to Watch for or Special Instructions: _____

Who to Contact with any Concerns, Questions, or Changes Observed: _____

Who to Contact in Case of Emergency Related to the Enteral Tube: _____

Signature of Consultative Nurse

Date