Ontario Health atHome

Enteral Feeding Referral Form: Adult/Pediatric

180 Riverview Dr Chatham, ON N7M 5K4
Telephone: 1-888-447-4468 Fax: 1-844-858-3546

Patient Information

Surname		First Name
Home Address		
City		Postal Code
Health Card Number	Version Code	Date of Birth (YYYY-Month-DD)

Enteral Feeding Tube Details

Type of Feeding Tube

- ◯ Nasogastric (NG tube)
- ◯ Gastrostomy (G tube)
- ◯ Gastrojejunostomy (GJ tube)
- ◯ Percutaneous Endoscopic Gastrostomy (PEG)
- ◯ Combination G/GJ tube
- ◯ Percutaneous Endoscopic Gastrojejunostomy (PEG-J)
- ◯ Jejunostomy tube (J tube)
- ◯ Other:
- ◯ MIC-Key Gastronomy tube (G tube)

Date of insertion (YYYY-Month-DD)	Tube Size	Name of Provider performing tube insertion

Plan for tube replacement

Formula Order

Name of formula	Daily amount (mL)
Current feeding rate cc/hour for hours	Goal feeding rate cc/hour for hours

Feeding Progression Instructions

- ◯ Community registered dietitian to progress according to tolerance and best practice guidelines
- ◯ Follow special instructions for feeding rates (please specify below)

Special instructions

Gravity, Pump or Syringe

Note: A signed prescription for feed including type and rate, as well as a completed Nutrition Products form from the physician must be faxed to the pharmacy providing the feed.

Pharmacy prescription sent to (Name)

Flushing and Oral Intake Requirements

Flushing Requirements

Oral Intake Restrictions/Recommendations

Surname	First Name	Health Card Number

Additional Information

Assistive Devices Program (ADP) Application initiated by (Name)	Date Submitted (YYYY-Month-DD)

Order Authorization

Physician/Nurse Practitioner Name (CPSO or CNO #)	Signature	Date Signed (YYYY-Month-DD)

Dietitian Name	Contact Name