Completed by:_____
Date:_____

Personal Feeding Tube Information

_____
(name)

Important contacts for questions or problems:

Health Care Provider: _____ Phone: _____
Health Care Provider: _____ Phone: _____
Nurse: _____ Phone: _____
Equipment Supplier: _____ Phone: _____

Type of Feeding Tube

- ☐ Naso-gastric tube (NG tube)
- ☐ Gastrostomy (G-tube)
- ☐ Jejunostomy tube (J-tube)
- ☐ Gastrostomy-jejunostomy tube (G-J tube)
- ☐ Other: _____

Feeding Tube Ports *(Health Care Provider will tell which port to use for food or medication)*

- ☐ One port tube – _____
- ☐ Two ports tube
  - Port 1 *(main port/larger port)* - _____
  - Port 2 *(smaller port)* - _____
- ☐ Three ports tube
  - Port 1 *(main port/larger port)* - _____
  - Port 2 *(smaller port)* - _____
  - Port 3 – _____

Feeding Tube Information

Brand Name: _____ Size: _____French
Balloon Size (for G-tubes): _____
Length (for NG tubes): _____
Reorder Number: _____
Date Inserted: _____
Inserted at (name of hospital or facility):_____

Infusion Pump & Supplies (Equipment)
Brand Name: _____ Manufacturer: _____
Pump Tubing Brand & Reorder #: _____

Nutritional Information
I use the following brand of formula:
_____

Method and Schedule
- □ Bolus
- □ Gravity drip
- □ Infusion Pump

Amount: _____ cc or ml
Times: _____
Special Instructions: _____

Flush Amounts

Before feeding	_____cc or ml
After feeding	_____cc or ml
During continuous feeding	_____cc or ml every _____ hours
Before medications	_____cc or ml
After medications	_____cc or ml

Extra Hydration/Fluids
I receive extra fluids:
- □ Yes
- □ No

If yes:
Amount per day: _____
Specific Instructions: _____

Special Instructions
How often do I need to see the doctor?

How often do I need to have my feeding tube replaced?

I should do this if my tube is clogged:

I should do this if my tube falls out: