WHEN DRUG FORMULA AND DOSAGE ARE IDENTICAL, THE PHARMACY MAY DISPENSE THE DRUG WHICH IS IN HOSPITAL STOCK REGARDLESS OF TRADE NAME UNLESS I SPECIFICALLY REQUEST "NO SUBSTITUTE." PHYSICIAN MUST DELETE ORDERS NOT DESIRED (DRAW A SINGLE LINE THROUGH THE ORDER). (IF BLANKS NOT FILLED IN, ORDERS CONSIDERED DELETED.)
Orders not to be initiated without physician signature and/or physician telephone authorization.

1PO

DO NOT WRITE OUTSIDE OF BORDER AREA

HOME ENTERAL THERAPY FEEDING ORDER

SW/DCP Name: _____ Phone_____ Pager_____

****

Information fax to vendor by SW/DCP: [check when done] **Date Faxed _____ by_____**

☐ Patient Demographic Sheet ☐ History & Physical ☐ Medication Sheet

☐ Lab result if available ☐ Nutrition Assessment

****

Enteral Therapy Order completed by MD/ARNP:

1) FORMULA ** If formula is to be concentrated, please include mixing instructions. Formula Name: _____**

Concentration: ☐ 20 kcal/oz ☐ 22 kcal/oz ☐ 24 kcal/oz ☐ 26 kcal/oz ☐ Other _____

2) AMOUNT _____ mL to be administered every 24 hours

3) FREQUENCY Bolus:_____ mL every _____ hrs _____ times daily

Continuous: _____ mL per hr x _____ hrs from _____ am/pm to _____ am/pm

☐ **Nasal Gastric Feedings:**
Neo Care Silicone Feeding Tube with Enteral Hub ☐ 6.5 Fr. X 1 (Stock at home & bring to hospital when necessary)
Date placed _____ (can remain in place up to 30 days)
Tubing mark at the nares _____ cm

Feeding Syringes X 10 (oral tip):	Medication Syringes X 10 (oral tip):	Dressing:	Medication:
☐ 60 mL ☐ 20 mL	☐ 60 mL ☐ 20 mL ☐ 3 mL ☐ 1 mL	☐ Occlusive Dressing (Tegaderm)	1. 2. 3. 4.

☐ **Feeding Pump**

☐ **Nasal Duodenum Feedings:**
Corpak Medsystems Enteral Feeding Tube with Stylet ☐ 6 Fr. ☐ 8 Fr. X 1 (to have at home)
Date placed _____ (can remain in place up to 30 days)
Tubing mark at the nares _____ cm
Flush with water 6 mL BID

Feeding Bags:	Medication Syringes X 10:	Dressing:	Medication:
☐ 500 mL ☐ 1,000 mL	☐ 12 mL ☐ 6 mL ☐ 3 mL ☐ 1 mL	☐ Occlusive Dressing (Tegaderm)	1. 2. 3. 4.

OTHER INFORMATION _____

HOME HEALTH ORDER FOR ☐ wt check ☐ hydration ☐ medication ☐ teaching ☐ Other_____

LIP PRINTED NAME:_____ PHONE: _____ PAGER:_____

LICENSE #: _____ NPI:_____ CLINIC #: _____

NAME OF VENDOR: _____ PHONE: _____ FAX: _____

DATE:**05/12/2011** TIME:**0927** LIP SIGNATURE: _____ ID #: _____

WHITE COPY: MEDICAL RECORD YELLOW COPY: UNIT

PROVIDENCE
Regional Medical Center
Everett

Colby Campus • 1321 Colby Ave.
Pacific Campus • 916 Pacific Ave.
Pavilion for Women and Children • 900 Pacific Ave.
Providence Regional Cancer Partnership
1717 13th Street • Everett, WA 98201

PLACE PATIENT LABEL HERE

Patient Name:_____

Birthdate: _____

HOME ENTERAL THERAPY FEEDING ORDER
(03/11)