Methodist Healthcare

ADULT ENTERAL NUTRITION ORDER FORM

Ht: _____ cm

Wt.: _____ kg

DATE & TIME	PHYSICIAN'S ORDERS AND DIET	DATE & TIME	PROGRESS RECORD
			Note Progress of Case, Complications, Consultations, Change in Diagnosis, Condition on Discharge, Instructions to Patient.

Please note: Prescribers must make selections in sections 1-5 of form.

1. Route of enteral nutrition (Check one) ☐ PEG or ☐ Continuous enteral feeding.

2. Enteral formula: (Check one)

❑ Ultracal (house formula, tube feeding with fiber)
❑ Isocal (isotonic tube feeding)
❑ Protain XL (high protein, fiber containing to support wound healing)
❑ Intensical (elemental nutrition for metabolically stressed patients, arginine enriched)
❑ Deliver 2.0 (high calorie, high nitrogen oral and tube feeding)
❑ Subdue (elemental nutrition for persons with impaired GI function)
❑ Glutasorb (high glutamine elemental formula)
❑ Choice DM (tube feeding for person with diabetes)
❑ Magnacal Renal (calorically dense formulation with electrolyte restriction)
❑ Other _____

3. Route specific orders:

IF PEG:

- Begin formula from above checklist on the following schedule:____cans every____hours
- When enteral nutrition starts, decrease IV to _____ mL/hr (if running).
- Free water flushes _____ cc's every _____ hours. (if needed)

If continuous nasogastric feeding:

- Begin tube feeding from checklist above at continuous rate of ____ cc's per hour.
- When enteral nutrition starts, decrease IV to _____ mL/hr (if running).
- Keep head of bed elevated 30-45° at all times.
- Check gastric residuals every 4 hours. Hold tube feeding for residuals> ____ cc's, or for abdominal distention, discomfort, or vomiting.

4. Routine orders (all routes of administration)

- Consult dietitian for nutrition recommendations.
- Strict I & O.
- Weigh daily.
- CMP, phosphorus, magnesium, triglyceride level and prealbumin in AM.
- BMP and prealbumin every Monday.

5. Blood glucose monitoring orders

Blood glucose monitoring every_____hour(s) with sliding scale regular human insulin.
Insulin route (Check one) ☐ **SQ** ☐ **IV**

Sliding scale (Check one)
❑ Sliding scale per P and T protocol
❑ Individualized sliding scale (write below)

_____ _____
_____ _____
_____ _____

Physician Signature:	**Date/Time**