



True Friends
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Office Use Only
 Session _____
 Cabin _____
 Cabin Copy _____
 Nurse Copy _____

Feeding Tube Questionnaire

To avoid service interruptions, we require this form to be on file before attending any True Friends program.
 Please plan to spend time with direct care staff and nurses to demonstrate/ assist with the first feeding/ medication.

Participant's Name: _____ Dates Attending: _____

Feeding Tube Kind: G-tube GJ J Other: _____ Type: Mic-Key Bard Button Other: _____

Lumen size: (Fr) _____ Length : _____ Balloon Size: _____

Position during feeding: _____ Feeding/Formula Type: _____

Directions if formula needs to be mixed:

Bolus Yes No Continuous Yes No Pump rate _____/hr Type of feeding pump: _____

Feeding Times:					
Amount (ml):					

Water Flush after feedings (amount) : _____ Water flush after medications: _____

Additional water allowed during the day: Yes No Amount: _____

Needed Supplies: Formula Syringes Extensions Feeding bags Feeding pump Battery Charger Extra G-tube
 Other _____ **Be sure to bring enough supplies to last for full duration of their stay plus 1 extra day)

If tube becomes dislodged, they will only be administered by a licensed health care professional.

Equipment will be cleaned with regular hand washing soap and water and hung to dry. If you require something different you will be required to bring your own supplies for cleaning.

Additional information:

 Name of Person Completing Form Relationship to Participant Phone Date