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 at check-in.

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 Brand 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 given:_____How often: _____

Needed Supplies: ☐Formula ☐Syringes ☐Extensions ☐Feeding bags ☐Feeding pump ☐Battery Charger ☐Extra G-tube ☐Other_____**Be sure to bring enough supplies, and site dressing 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. Please explain emergency protocols for dislodged tubes: _____

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