Alberta Health Services

Pediatric Tube Feeding Care Plan

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X)	

Developed And Shared with *(Name of family Member)*	Date *(dd-Mon-yyyy)*
Child's Preferred Name *(Last name, first name)*	
Medical Conditions	
Food Restrictions or Allergies	
Emergency Contacts	

Oral Feeding

Concerns with:	Comment
Safely feeding by mouth ☐ Yes ☐ No	
Safely drinking ☐ Yes ☐ No	

Oral Recommendations *(check all that apply)*

- ☐ No food or drink by mouth
- ☐ Stimulation
- ☐ Eat or drink as desired
- ☐ See *Oral Feeding Care Plan* for additional details

Tube Feeding

Reason for Feeding Tube	
Name/Type of Tube	Size of Tube *(French)*
Date of Tube Insertion *(dd-Mon-yyyy)*	Date of last Tube Change *(dd-Mon-yyyy)*
Feed Type *(Breastmilk, Formula, Home Blended Food)*	
Calorie Concentration	Total amount each day
Recipe *(include a detailed recipe where applicable)*	

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Tube Feeding continued

Feeding Routine and Administration Instructions

☐ Gravity ☐ Syringe ☐ Pump _____

Provide details *(time of day feeds should be provided, amounts, rate and how long feeds should be run over, etc.)*

Feeding Position

Hang Time *(Indicate the number of hours the feeding type/recipe can remain at room temperature)*

☐ 8 hours ☐ 4 hours ☐ 2 hours ☐ Other _____

Flushes

☐ Tap water ☐ Boiled water ☐ Other _____

☐ Before each feeding _____ mL

☐ After each feeding _____ mL

☐ Every _____ hours, flush with _____ mL of water

☐ Extra water throughout the day _____ mL

☐ Before and after each medication with _____ mL of water

☐ Other _____

Medication

☐ Provide by mouth ☐ Provide by tube

Instructions

Recommendation

Vitamin, Mineral and Supplement

☐ Provide by mouth ☐ Provide by tube

Instructions

Recommendation

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Formula and Supplies Access

☐ Retail purchase ☐ Home Nutrition Support Program *(co-pay)*

Funding source	Funding application status
☐ Letter provided ☐ Prescription requested	
Supplies ordered from *(specify)*	
Formula required *(cases per year)*	Module/Additive *(cases per year)*

Tube Feeding Safety and Precautions

☐ Boiled water use until 4 months of age
☐ Check the feeding tube at the beginning of the day and before each feed *(secure, not too tight or loose, stoma)*
☐ Use a tubing stabilizer to avoid tangled tubing
☐ Wash the feeding bag/tubing every _____
☐ Supervision required
☐ Child needs help to set up
☐ Other _____

Growth Monitoring

☐ Growth trend _____ ☐ Growth chart attached

Weight *(kg)*	Length/Height *(cm)*	Date measured *(dd-Mon-yyyy)*
Frequency to be done		To be completed by
Call Weights to *(name)*		Phone

Tube and Stoma Care

☐ Clean tube site every _____
☐ Balloon Checks _____
☐ Vent tube when _____
☐ Vent the feeding tube before/after feeds
☐ Vent the feeding tube every _____ hours for _____ minutes
☐ Apply _____ to tube site every _____
☐ Other _____

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Education

- ☐ PEAS Website www.peas.ahs.ca
- ☐ Tube Feeding at Home Booklet
- ☐ Tube specific Handout
- ☐ Stoma care Handout
- ☐ Cleaning tube feeding supplies
- ☐ Flushing
- ☐ Feeding instructions and routine
- ☐ Formula preparation
- ☐ Medication Administration
- ☐ Pump instructions and care
- ☐ Troubleshooting
- ☐ Tube care, venting
- ☐ Other _____

Additional Recommendations

Feeding Care Team Contact
(contact your healthcare team if you have questions or concerns about the tube feeding plan)

Dietitian	Phone
Date Reviewed	Date of next appointment *(dd-Mon-yyyy)*
Home Nutrition Support Program	Phone
Date Reviewed	Date of next appointment *(dd-Mon-yyyy)*
Speech Language Pathologist	Phone
Date Reviewed	Date of next appointment *(dd-Mon-yyyy)*
Occupational Therapist	Phone
Date Reviewed	Date of next appointment *(dd-Mon-yyyy)*
Physician	Phone
Date Reviewed	Date of next appointment *(dd-Mon-yyyy)*
Other Team Member	Phone
Date Reviewed	Date of next appointment *(dd-Mon-yyyy)*

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