Pediatric Feeding & Swallowing
Tube Feeding Intake Form

History

Type of feeding tube (please circle):

G-Tube Date of surgery: _____ Nissan? Yes/No

J-Tube Date of surgery:_____

NG-Tube Date of insertion: _____ Total duration: _____

NJ-Tube Date of insertion: _____ Total duration: _____

Any complications? _____
_____

Who monitors/adjusts your child's tube feedings? _____

Is a dietitian working with your child? Yes/No
Name: _____ Frequency: _____

Current Feeding

What formula goes into the feeding tube? _____

What else goes in the feeding tube?_____

Do you add water? Yes/No

If yes, please describe when & amount:_____
_____

Who usually tube feeds your child? _____

Who else? _____

Where is your child tube-fed? Please circle.

Highchair Adult's lap Crib/Bed Adult's Lap

Feeding Schedule

Are tube feedings with a syringe or feeding pump? _____

Please provide current feeding schedule:

Continuous Feed: Rate- _____cc's/hr Duration: _____ hours
Beginning time: _____ End time: _____

Bolus feeds: Rate- _____cc's/hr Total volume: _____cc's/ml's
Total # of feeds/day: _____
Time of feeds: _____

Problems

Have you had difficulty increasing the rate or volume of your child's tube feedings? Yes/No

Does you child retch/vomit? Yes/No

If yes, how often does this occur? _____

Any particular time of day? _____

What do you attribute the vomiting to? _____
_____

How much does your child typically vomit? _____

Does your child cry during tube feedings? Yes/No

Does your child resist being tube fed? Yes/No

If yes, describe: _____
_____
_____
_____
_____

Anything else you think we need to know: _____
_____
_____
_____
_____