The Arc of San Antonio
Serving People with Intellectual and Developmental Disabilities

Gastrostomy Feeding Form

Site Name:

Please assist: _____ **DOB:** _____
with taking the following nutritional feeding:

Type of Formula/fluid: _____
Amount of Water for Administration:_____
Time(s) feedings are to occur: _____

Amount of Each Feeding: _____ Total Amount of water with each feeding: _____

Pump Setting or Flow Rate (if applicable): _____ Flow to Gravity: _____

Flush with: _____ml of water before and after each feeding

Additional Instructions (please include if feeding is supplement to food, PRN, or routine):

_____

_____

_____

_____

Prescribing Physician Name and Phone Number:

_____

_____ _____
Physician Signature **Date**

I understand that I must provide staff of The Arc with all of the necessary supplies to provide G-tube feedings for _____In addition, it is understood that I must provide a new feeding syringe and extension tubing every few weeks or as needed to prevent mold or staff will be unable to assist with the feeding.

In sum, I give my permission for the staff of The Arc to assist _____with G-tube feedings according to the instructions listed on this page. I **DO** / **DO NOT** authorize the nurse, when available to replace/reinsert G-tube should it be removed for any reason.

_____ _____
Parent/Guardian Signature Date