AM NUTRITION SERVICES

"Providing Tools and Enhancing Skills To Improve Your Nutritional Health"

Tube Feeding Questionnaire

Please fill out all information and sign below. Completing this form is required prior to your first appointment.

Your Name _____ DOB _____

Tube feeding formula name _____

Route of infusion (G-tube, J-tube, etc.) _____

_____

_____

Rate of infusion _____

Water flushes _____

Reason for tube feeding and anticipated discharge date of tube feeding, if applicable_____

_____

_____

_____

_____

Please share if you've had any complications or issues tolerating the formula (nausea, vomiting, diarrhea, constipation, etc. _____

_____

_____

_____

Please share your weight history before starting tube feeding and since you've been on tube feeding

_____

_____

_____

Have there been any recent changes to your formula or rate? _____

_____

_____

Who administers your tube feeding? _____

_____

Who is your home health company? _____

_____

Are you able to consume any foods orally? _____

Please share any other information that may be helpful for your dietitian to have prior to your visit

_____

_____

_____

Signature _____ Date _____/_____/2022 ____

Thank you for taking the time to complete this form! – AM Nutrition Team