

# Monthly Tube Feeding Report

Name: \_\_\_\_\_ Room number: \_\_\_\_\_

<b>Tube Feeding:</b> <input type="checkbox"/> NG tube <input type="checkbox"/> GT/PEG <input type="checkbox"/> JTT		
Formula: _____	Total mL/day: _____	
Continuous feeding: _____ mL x _____ hours	Bolus: _____ mL x _____ feedings/day	
Flushes: _____		
Total volume of feeding: _____	Total free water (feeding+flush): _____	
Total kcal/day: _____	Protein: _____ g	
Rationale for tube feeding: _____	Potential for oral feeding: _____	
Tolerance of tube feeding: _____		
Within this period, resident has/had (check and put date next to when occurred)		
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dehydration	<input type="checkbox"/> Vomiting/distention
<input type="checkbox"/> None of these		

**PO diet order:** \_\_\_\_\_ **Oral supplement:** \_\_\_\_\_

Estimated PO intake of foods:  Good (71%-100%)  Fair (50%-70%)  Poor (0%-49%)

## Pressure ulcer:

Stage and site: \_\_\_\_\_

Stage and site: \_\_\_\_\_

## Supplements:

Multivitamin  Vitamin C  Zinc  Other: \_\_\_\_\_

Protein \_\_\_\_\_  Not on vitamins/mineral supplements

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ 30-day weight: \_\_\_\_\_

UBW: \_\_\_\_\_ Weight change %: \_\_\_\_\_

Significant lab data: \_\_\_\_\_

## Nutritional requirements:

Estimated calorie needs/REE or kcal/kg: \_\_\_\_\_

Protein: g/kg \_\_\_\_\_ Fluids: mL/kg \_\_\_\_\_

**Are nutrients met for:** Kcal: Yes  No  Protein: Yes  No  Fluids: Yes  No

## Additional comments/recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dietitian's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_