

**CARE PLAN  
ENTERAL**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**I. Administration and Operation of Equipment: (Circle One)**

- A . Bolus
- B . Gravity
- C . Pump

**II. Goal:**

Patient/caregiver will be able to properly administer enteral feeding, give a return demonstration and operate equipment according to \_\_\_\_\_ policy and procedure.

Patient will achieve/maintain goal weight of \_\_\_\_\_ lbs

Specific patient goals: \_\_\_\_\_

**III. Intervention/Actions to Achieve Goals:**

Phone or visit patient every \_\_\_\_\_ days.

Obtain patient's weight (actual or estimated) every \_\_\_\_\_ days.

Re-evaluate patient/caregiver level of understanding every \_\_\_\_\_ days.

Nutricor evaluation every 90 days    \_\_\_\_\_ YES    \_\_\_\_\_ NO

Lab drawn by \_\_\_\_\_ Staff    \_\_\_\_\_ HHA    \_\_\_\_\_ Physician

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. G.I. Access:** \_\_\_\_\_

**V. Formula:** \_\_\_\_\_ Prescribed Rate: \_\_\_\_\_

Frequency: \_\_\_\_\_

Delivery Schedule: \_\_\_\_\_

**UTILIZATION:** To be completed at start of care and update PRN annually.

Staff Signature: \_\_\_\_\_