



Very Special Kids

Feeding and Food Chart Enteral

GOLDCARE NUMBER (CLIENT ID)

GIVEN NAME

FAMILY NAME

DATE OF BIRTH

SEX MALE

Nutrition Formula Instructions – Gastrostomy/Nasogastric Feeds

Gastrostomy/Nasogastric Type: Size: Balloon Volume: <i>(if applicable)</i>	Method of delivery: Rate:	Feeding Position: <input type="checkbox"/> Chair <input type="checkbox"/> Wheelchair <input type="checkbox"/> Tumbleform <input type="checkbox"/> Other	Formula Type:
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To make up the formula: if applicable (if N/A score through)

Time	Name of Feed	Volume	Rate	Flush

Please advise of any concerns or issues with feeding your child.
Any special feeding equipment?

Family member Signature		Date:
Staff Signature		Date:
Designation		