R	OYAL ADELAIDE HOSPITAL		PATIENT	ΓLABEL									
CLINICAL Unit Record No.:					 								
	NUTRITION CHART	Patient Name:			 								
		Contact No:											
	of	Date:											
					 · · · · · · · · · · · · · · · · · · ·								
		Date & Month —											
	DIETITIAN MUST ENTER ADMINISTRATION TIM												REASON FOR NURSE NOT ADMINISTERING Codes MUST be circled
Date	Product (Print full product name) Contai	iner Tick if ORAL											Absent
		supplement											
Route	Method Pump Rate Dose (ml) Fre	equency. Enter times —											
	ml/hr												On Leave
Signature		Contact											Not available - obtain supply or Contact Dietitian
													Refused - Notify Dietitian
Data	Deaduct (Driet full product name) Conta	inor										_	
Date	Product (Print full product name) Conta	iner Tick if ORAL											Self Administered
		supplement											Vomiting— Notify Dietitian & Doctor
Route	Method Pump Rate Dose (ml) Fre	equency. Enter times —											Withheld— Enter reason in Clinical Record
	22/02												Cillical Record
Signatur	ml/hr Print Name & Designation	Contact											FEED TUBE SPECIFICATIONS
3													TYPE and location
													EDENOU
Date	Product (Print full product name) Contain	if											FRENCH
		ORAL supplement											SHAFT LENGTH
Route	Method Pump Rate Dose (ml) Fre	equency. Enter times											INSERTION DATE
Signatur	re Print Name & Designation	Contact											
Joignatur	Time Name & Designation	Contact					_						ADDITIONAL CHARTS
													Fluid Balance Chart
Date	Product (Print full product name) Contain	if											Nutrition Observation Chart (MR 124.0)
		ORAL supplement											Weight Chart (MR 104.0)
Route	Method Pump Rate Dose (ml) Fre	equency. Enter times											BGL Chart
													Food Intake Chart
Signatur	re Print Name & Designation	Contact											
Olgridius	Time varie & Designation	Contact					_						KEY FOR USE
													The Clinical Nutrition Chart is for all enteral nutrition & structured oral nutrition support . The chart uses similar operating procedures
Date	Product (Print full product name) Contain	if											to the National Inpatient Medication Chart (NIMC). Enteral & oral nutrition support is
		ORAL supplement											provided via your Clinical Dietitian.
Route	Method Pump Rate Dose (ml) Fre	equency. Enter times											DATE: date order was written. PRODUCT: brand name in full (Jevity with Fibre, Jevity Hi Cal, Two Cal HN etc)
													CONTAINER TYPE: Ready to Hang (RTH), 237ml can, 250ml tetra etc.
Signatur	re Print Name & Designation	Contact											TICK IF ORAL SUPPLEMENT: clear identification of oral vs enteral.
Oignatur	Time value a Besignation	Contact											ROUTE: NET, JEJ, PEG, Oral (PO) etc METHOD: syringe, pump, gravity, oral PUMP RATE: ml/hour for feed delivery via
													pump.  DOSE: volume for each dose; ie med pass 50ml
Date	Product (Print full product name) Conta	if											dose x 4 (QID frequency), or 1000ml dose.  FREQUENCY: OD, BD, TDS, QID, Bolus,
		ORAL supplement											Continuous TIMES: Times are written in adjacent vertical
Route	Method Pump Rate Dose (ml) Fre	equency. Enter times											column SIGNATURE:Clinician's signature
													PRINT NAME & DESIGNATION: Clear identifi- cation of authorising clinician. May include: Clinical Dietitian - all nutrition support
Cienct	ml/hr Print Name & Decignation	Contact											Medical Officer - NET insertion & length documentation)
Signatur	Print Name & Designation	Contact											Speech Pathologist - thickened fluid orders CONTACT: Pager, mobile, speed dial (indicate)
													, <u> </u>

## TRANSITION FEEDING or DIETITIAN AUTHORISED TELEPHONE ORDERS

	DIETITIAN	N MUST ADVISE A & TRANSITIO		TION TIMES _	YEAR			
Date	Product (P	rint full product na	product name) Container ty		Tick if ORAL supplement			
Route	Method	Pump Rate	Dose (ml)	Frequency. I	nter times			
Signature Print Name & Designation Cor					act			
Date	Product (P	rint full product na	me) (	Container type	Tick if ORAL supplement			
Route	Method	Pump Rate	Dose (ml)	Frequency. I	enter times			
Signature	•	Print Name &	Designation	Conta	act			
Date	Product (Print full product name)			Container type	Tick if ORAL supplement			
Route	Method	Pump Rate	Dose (ml)	Frequency. I	enter times			
Signature Print Name & Designation Contact					act			
Date	Product (P	rint full product nar	me) (	Container type	Tick if ORAL supplement			
Route	Method	Pump Rate	Dose (ml)	Frequency. I	nter times			
Signature	9	Print Name &	Designation	Conta	act			
Date	Product (Print full product name)			Container type	Tick if ORAL supplement			
Route	Method	Pump Rate	Dose (ml)	Frequency. I	Enter times			
Signature Print Name & Designation				Conta	act			

CLINICAL NUTRITION CHART

MR96.0