Complete and maintain in Individual's Record

Gastrostomy(G) or Jejunostomy(J) Tube Management Form

Date:	DPH MAP Massachusetts Controlled Substances Registration (MCSR):
Service Provider:	MAP Registered Site Address:
Staff to Individual Ratio:	
Staffing Pattern:	

Name of Individual who has a G or J Tube: _____

Date of Birth: _____

Type of Tube (s): ☐ Gastrostomy

☐ Jejunostomy

Date of Placement of G or J Tube (approximate if necessary): _____

Section Below to be completed by the Health Care Provider (HCP):

Reason for Placement of G or J Tube:

☐ Dysphagia

☐ Chronic Aspiration

☐ Nutrition Concerns

☐ Hydration Concerns

☐ Other: _____

☐ Unknown

Check applicable box, if this person may:

☐ Receive feedings via their G or J Tube

☐ Receive hydration via their G or J Tube

☐ Receive medications via their G or J Tube

☐ Have medications administered via their G or J Tube 'only' by a licensed nurse

☐ Have medications administered via their G or J Tube by a non-licensed MAP Certified Staff

* ***If medications may be administered via the G or J Tube by unlicensed MAP Certified staff, the Health Care Provider (HCP) must complete the section below:***

I have evaluated this individual and have determined that **the stoma site/tract is mature** (i.e., the tract is well-established) and it is **appropriate at this time for MAP Certified (non-licensed) staff** to be trained to administer medications via their:

_____ Gastrostomy Tube	HCP initial's:
_____ Jejunostomy Tube	HCP initial's:

Printed Name of Health Care Provider: _____ Telephone Number: _____

Signature of Health Care Provider: _____ Date: _____

MAINTAIN IN INDIVIDUAL'S RECORD