*REQUIRED*

*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 toIndividual 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:*** |

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| --- |
| I have evaluated this individual and have determined that **the stoma site/tract is mature** (i.e., the tractis 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 CareProvider:  | Telephone Number:  |
| Signature of HealthCare Provider:  | Date:  |
|  *MAINTAIN IN INDIVIDUAL’S RECORD*  |

Complete and maintain in Individual’s Record Rev\_06-28-23