

## Individual Gastrostomy Feeding Plan

Name

D.O.B:

Type of Milk/Additives e.g. Nutrison, Gaviscon	Administered via bolus or Infinity pump	Dose/Rate	Time to be administered	Volume of pre/post feed flushes

**This plan has been agreed by:**

**Parent/Carer:**

**Date:**

Health & Wellbeing

Support Worker:

Date: