Exhibit B

Division of Developmental Disabilities
Enterostomy Tube Information Form Shared Living Provider (Non-Nurses)

Name of Service Recipient:_____ **MCI#:** _____

Check Type of Tube: **Gastrostomy** _____
Jejunostomy _____

Date of Tube Placement (approximate if necessary): _____ **Check Reason for Placement of enterostomy tube:**

Dysphagia_____ **Chronic aspiration** _____
Choking_____ **Nutritional Concerns** _____
Hydration Concerns_____ **Unknown**_____
Other (Please specify) _____

Does this person?

Receive feedings via their enterostomy tube?	**Yes**	**No**
Receive hydration via their enterostomy tube?	**Yes**	**No**
Receive routine water flushes?	**Yes**	**No**
Receive medications via their enterostomy tube?	**Yes**	**No**

****

I am aware that the Division of Developmental Disabilities Services (DDDS) has determined that _____ **has successfully completed training**
Name of Shared Living Provider

and demonstrated competency relative to the feedings, hydration, and/ or administration of medication for _____
Name of Service Recipient Receiving Services

via the following route:

Gastrostomy Yes No **Jejunostomy Yes No**

_____ _____
Printed Name of Healthcare Provider **Signature of Healthcare Provider**

_____
Date of Signature

Reviewed: 01/01/23
Form # 26