NG TUBE INSERTION RECORD
FOR USE IN PATIENTS BEDSIDE CARE PLAN OR MEDICAL NOTES

Patients Name:

Patients ID:

Ward:

Lot Number:

NG Manufacturer:

The Tube Size Is:

FR

CM

NG Tube Insertion Date:

DD

MM

YY

YYYY

Time:

HH

MM

Nostril Used:

Right

Left

Length of NG tube at nose:

At nostril once secured

CM

CM

Inserter’s Signature:

Designation:

ID:

Aspirate Obtained:

Yes

No

pH Value:

Designation:

ID:

Signature:

Second signature if required by local policy for pH 5 or 5.5

2nd Signature:

Designation:

ID:

As per Trust guidelines if no aspirate obtained, or if pH is 5.5 or above.

X-ray Required?:

Yes

No

Most recent X-ray reviewed?

Yes

No

Date of X-ray:

DD

MM

YY

YYYY

Time of X-ray:

HH

MM

Confirm path of the tube:

Y

N

Following the oesophagus

Y

N

AND bisects the carina

Y

N

AND crosses diaphragm in the midline

Y

N

AND the tube is clearly visible below diaphragm

SAFE TO FEED

Yes

No

Signature:

ID:

Designation:

ID:

Clinician Signature:

Date:

Time:

Designation:

ID:

Insert sticker in to bedside care plan or medical notes. Ensure patient specific details are clearly documented, including consent details and any difficulties encountered when inserting the NG Tube.

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