



Gastrostomy Proforma

(Affix patient identification label here)

You have been sent this proforma for completion because you have referred a child for consideration of a Gastrostomy placement. The below information is vital to ensure this child is reviewed in the monthly MDCC, allocated a category for surgery, and advanced through to surgery if appropriate.

URN: Name: Date of birth:

HOME Hospital & Health Service:

Treating team and Consultant:

Date of referral:

Should the child proceed to surgery for creation of a Gastrostomy feeding tube, please note:

1. The care of the gastrostomy will be transferred after 6 months, to the HOME treating team consultant, and local hospital.
2. If there are nutritional concerns, this would constitute a separate referral to Gastroenterology.
3. The referring team will continue to provide ongoing care.

Parents / Guardians have agreed to Gastrostomy insertion and are aware of referral ☐ Yes ☐ No

Parents are still undecided and request further information ☐ Yes ☐ No

Current weight: kg Height centile: Wt for Ht Z score:

Is the child currently on NGT or TPT feeds? ☐ Yes ☐ No When was this initiated?

Indication for Gastrostomy:

Unsafe swallow e.g. neurological / anatomical / aspiration risk? ☐ Yes ☐ No

Inadequate oral intake. Has NGT / TPT been trialed? ☐ Yes ☐ No

Non-nutritional reasons? ☐ Yes ☐ No

If yes, specify:

Will this condition be longer than 6-12 months? ☐ Yes ☐ No

ARFID: If micronutrient deficient, have a Paediatrician and a Dietitian been engaged in care? ☐ Yes ☐ No

Have supplements, including micronutrients, been trialed >12 months? ☐ Yes ☐ No

Other information / concerns initiating referral for Gastrostomy, including current medication:

Does the child have any of the following symptoms, surgical considerations or had any of the following investigations?

Vomiting ☐ Yes ☐ No

Frequency and duration:

Bilious / non bilious:

Have PPI's been trialed? ☐ Yes ☐ No

Gagging ☐ Yes ☐ No

Frequency:

Feed-related:

Gastroscopy ☐ Yes ☐ No

If yes, where and when?

Can the child manage oral secretions? ☐ Yes ☐ No

If no, have any medications or

procedures been trialed? ☐ Yes ☐ No

Severe Scoliosis ☐ Yes ☐ No

Previous abdominal surgery over
LUQ or major abdominal surgery ☐ Yes ☐ No

Any implantable devices
e.g. VP shunt, pacemaker,
neurostimulator ☐ Yes ☐ No

Splenomegaly / portal hypertension ☐ Yes ☐ No

Coagulopathy or Haematological
conditions ☐ Yes ☐ No





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URN:

Name:

Date of birth:

Does the child have any of the following teams engaged in their care? If yes, please include name and HHS if applicable.

Paediatrician, willing to manage nutrition and care for the child, both pre and post gastrostomy insertion?

Name:

Dietitian, currently managing nutrition and care for the child, and willing to manage post gastrostomy insertion, including supply of feeding pump, parental / carer education of use of pump and access to pump consumables and feed.

☐ Yes ☐ No

Name:

Current feeding regime:

Speech Pathologist

Name:

List all assessments undertaken looking for signs of oromotor dysfunction:

Occupational Therapist

Name:

Does child have significant procedural anxiety? ☐ Yes ☐ No

Does the child pull out NGT / TPT? ☐ Yes ☐ No

If yes, how frequently? ☐ Daily ☐ Few times per week ☐ Weekly ☐ Fortnightly ☐ Rarely ☐ Other

Social Worker supporting psychosocial complexities that may impact on the ability to adequately care for a child with a gastrostomy tube e.g. housing, access to health services, other? Please elaborate:

Connected Care / Nurse Navigator ☐ Yes ☐ No

NDIS ☐ Yes ☐ No

Paediatric Palliative Care Service ☐ Yes ☐ No

Do the parents have guardianship? ☐ Yes ☐ No

Is Child Safety involved with this patient? ☐ Yes ☐ No

If applicable, please include DoCS contact details:

Does the child require anaesthetic assessment/ high anaesthetic risk?

☐ Yes ☐ No

• Chromosomal abnormality associated with syndrome or other structural changes

☐ Yes ☐ No

• Congenital cardiac abnormality/ previous cardiac surgery?

▪ Recent assessment by cardiology and stable

☐ Yes ☐ No

▪ If *no*, has a referral to Cardiology been completed

☐ Yes ☐ No

• Micrognathia or other causes for difficult airway

☐ Yes ☐ No

• Respiratory conditions e.g. requires home oxygen

☐ Yes ☐ No

• Known seizure disorder

☐ Yes ☐ No

▪ Has current *seizure emergency management plan*

☐ Yes ☐ No

• Family history of Malignant Hypothermia

☐ Yes ☐ No

• Other anaesthetic issues, including behavioural issues/ significant procedural anxiety

☐ Yes ☐ No

Name:

Date:

Designation:

Please attach to your GPSR referral and/or email to your local service via normal processes.

DO NOT WRITE IN THIS BINDING MARGIN