ROOM NUMBER _____

DATE _____

NURSE SIGNATURE _____

FOOD ALLERGIES _____

ASSISTIVE DEVICE _____

SKIN CONDITION _____

EATING ABILITY: SELF ☐ ASSIST ☐ TOTAL ASSIST ☐

RESIDENT NAME _____

DIAGNOSIS _____

- ☐ NEW RESIDENT
- ☐ DISCHARGE
- ☐ DIET CHANGE
- ☐ HOLD TRAY UNTIL _____
- ☐ ROOM CHANGE FROM _____ TO _____

CHECK ALL BLANKS THAT APPLY

DIET ORDER

- ☐ REGULAR
- ☐ NO ADDED SALT (Less than 4.5 Gm. NA)
- ☐ NO CONCENTRATED SWEETS
- ☐ 2 GRAM SODIUM
- ☐ SALT SUBSTITUTE
- ☐ LOW FAT OR LOW CHOLESTEROL
- ☐ FULL LIQUID (48 hours only)
- ☐ CLEAR LIQUID (24 hours only)
- ☐ NPO - PARENTERAL NUTRITION
- RENAL ☐ 70 gm Pro, NAS, 3 gm K^+
- ☐ 60 gm Pro, 2 gm Na^+, 2-2.5 gm K^+
- ☐ MECHANICAL SOFT NAS
- ☐ MECHANICAL SOFT NCS
- ☐ PUREE NAS
- ☐ PUREE NCS
- ☐ ☐ 1500 CAL ☐ 1800 CAL
- ☐ OTHER _____

TEXTURE: DENTURES: ☐ YES ☐ NO

- ☐ MECHANICAL SOFT ☐ THREE DAY TEXTURE TRIAL
- ☐ PUREE ☐ THREE DAY TEXTURE TRIAL
- ☐ ENTERAL NUTRITION: FORMULA: _____

_____ cc _____ calories in _____ hours

Flush with _____ cc water every _____ .

- ☐ NPO FOR _____ HOURS

BEVERAGE: COFFEE, DECAF, TEA, MILK

FOOD PREFERENCES: _____

_____

_____

DIET ORDER FORM

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