

Diet Order Communication Form

Name: _____

Room No. _____

New Admit: _____

Change In Diet: _____

Discharge: _____

Referral to Registered Dietitian: _____

Available Diets

- | | |
|--|---|
| <input type="checkbox"/> Regular | <input type="checkbox"/> Gluten Free |
| <input type="checkbox"/> No Added Salt (NAS) | <input type="checkbox"/> High Fiber |
| <input type="checkbox"/> Finger Foods | <input type="checkbox"/> Renal |
| <input type="checkbox"/> Consistent Carbohydrate (CCHO) | <input type="checkbox"/> Liberal Renal |
| <input type="checkbox"/> Fortified Foods | <input type="checkbox"/> Liberal Renal CCHO |
| <input type="checkbox"/> Heart Healthy (Low Fat/Low Cholesterol) | (Consistent Carbohydrate) |

Diet Precautions

- Diabetic Precautions
- Heart Healthy Precautions
- Renal Precautions
- Sodium Precautions

(Diet Precautions are listed in the Individualized Plan of Care and on the Tray Card.)

Consistency

- Dental Soft (Mechanical Soft)
- Pureed
- Level 1: Dysphagia Pureed
- Level 2: Dysphagia Mechanically Altered
- Level 3: Dysphagia Advanced

Thickened Liquids

- | | | |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Nectar-like | <input type="checkbox"/> Honey-like | <input type="checkbox"/> Spoon-thick (pudding) |
|--------------------------------------|-------------------------------------|--|

Other

- | | |
|------------------------------|--|
| <input type="checkbox"/> NPO | <input type="checkbox"/> Tube Feeding _____
(specify) |
|------------------------------|--|

House Supplement:

Amount _____ Times Per Day _____

Food Allergies: _____

Comment/Request: _____

Signed: _____

Date: _____