Resident Name: _____ **DOB:** _____

Therapeutic Diet Orders

Known Food Allergies: _____

☑	Type	Description
☐	Regular	This diet is for residents who do not require any diet modifications or that do not have dietary restrictions.
☐	No Concentrated Sweets Diet (NCS)	This diet restricts foods high in sugar or other concentrated sweets. This diet is for diabetic residents. In addition to the prescribed menu, no sugar will be provided on the table. This diet does allow for additional portions of foods low in carbohydrates, starch, and sugars.
☐	No Added Salt Diet (NAS)	This diet restricts foods high in sodium. This diet is the least restrictive sodium controlled diet that needs a menu. By selecting this diet we may also limit the residents access to table salt, and high sodium foods such as canned soup are limited to no more than three (3) times per week.

Modified Consistency		
☐	None	Foods served as prepared.
☐	Pureed	This diet modification is designed to provide foods of a smooth, soft consistency, like whipped potatoes. Pureed foods should hold their shape without liquid separating them. Thickeners may be used. This diet is typically selected for residents with swallowing problems.

Thickened Liquids					
☐	Not Applicable				
☐	Nectar	☐	Honey	☐	Pudding

Fluid Restriction	
☐	Not Applicable

Fluid Intake not to exceed _____cc's in a twenty-four (24) hour period including all facility provided meals and breaks.

Other Dietary Orders
☑ Resident may participate in a diet holiday by occasionally receiving a regular diet for holidays and other special events, consistency and thickened liquid orders still apply.
☐ Double Portions. Resident is to receive double portions at all meals, of foods allowed within the above listed dietary restrictions. This is for residents that are suffering from weight-loss and have an abnormally low BMI. Should be used in addition to dietary supplement shakes.

Patient Specific Dietary Orders:

By signing below the provider is authorizing this diet order to be in effect for a six (6) month period, unless additional orders are obtained.

Provider's Signature: _____ **Date:** _____