

CHEWING ABILITY:		SWALLOWING ABILITY:	
COMMUNICATION:		MENTAL ACUITY:	
APPETITE:	DIET ACCEPTANCE:	CULTURAL FOODS:	
HEIGHT:	WEIGHT:	AGE:	
DESIRABLE WEIGHT:		ACTIVITY LEVEL:	
RECOMMENDED CALORIC INTAKE:			

DATE	WEIGHT CHART	DATE	LABORATORY DATA	MEDICATIONS

DATE ADMITTED:		VISITATION RECORD	
DATE	DIET PRESCRIPTION	DATE	COMMENTS

PHYSICIAN: _____ **DIAGNOSIS:** _____

NAME: _____ **ROOM:** _____ **DIET ORDER:** _____