# NUTRITION AND FOOD SERVICES

# ACUTE CARE/LTC MEALTRAY AUDIT FORM

DATE: ____________________ FACILITY: ______________________________

MEAL SURVEYED (Check one): Breakfast _________ Lunch _________ Supper _________

DIET/TEXTURE: _________________________ COMPLETED BY: ________________________

Mark all areas with YES, No, or N/A

| Tray Item | Does the meal smell appetizing? | Does the meal taste appetizing? | Is the texture correct? | Is the temperature appropriate? | Is the portion size adequate? | Is the appearance appetizing? | Action Taken | Initial | Follow Up | Initial |
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| **General Observations** | | | | | Y/N | Y/N | | | | |
| **Tray Accurate to diet order** | | | | | | | | | | |
| **Tray Clean** | | | | | | | | | | |
| **Packaging easy to access / no damage** | | | | | | | | | | |
| **Overall presentation is acceptable** | | | | | | | | | | |

# "Yes" Responses / Total # of Yes & No Responses x 100% = ______