DIET CHANGE FORM
PERSONAL CARE HOME

Addressograph

Date: _____ ☐New Admission ☐Diet Change

Ward:_____ Room #_____

ALLERGIES (RED INK ONLY):_____

INTOLERANCES:_____

DIETS:	**PORTIONS:**	**EATING AIDES**
☐Regular ☐Carbohydrate Controlled ☐Other: _____	☐Small ☐Regular ☐Large ☐Other: _____	☐Special Plate/Plate Guard ☐Large Handled Cutlery ☐Mug ☐Other: _____
TEXTURES:	**FLUIDS:**	**SENSORY NOTES/DEXTERITY:**
☐Regular ☐Soft ☐Minced ☐Total Minced ☐Pureed ***Ordered by SLP or RD only** ☐*Soft with Minced Meat (For chewing difficulties only) ☐*Blenderized ☐*No Fluids Combined with Solids ☐*Extra Sauces/Gravies Texture change supported by TTMD-R? ☐Yes ☐ No If No, why was the texture changed? _____	☐Thin (Level 0) ☐Mildly Thick (Level 2) ☐Moderately Thick (Level 3) ☐Extremely Thick (Level 4) ☐Fluid Restrict _____ mL/day	☐Poor Hearing ☐Poor Vision ☐Other: _____ ☐Cut Up ***used for poor dexterity only** ☐Meat Only ☐All Foods

NUTRITIONAL SUPPLEMENTS:	
☐Initiate ☐Discontinue ☐Change	Supplement Requested: _____ Amount and Frequency: _____ Meal: _____

LIKES	**DISLIKES**
_____	_____
_____	_____
_____	_____

DETAILS OR COMMENTS

☐The plan was discussed with the resident and/or family (substitute decision maker); and has agreed to the plan outlined.

☐**Resident Integrated Care Plan – Nutrition section has been updated**

Nurse/RD signature: _____ Date:_____

☐**Implemented by Dietary**

Dietary staff signature_____ Date:_____

☐**Nutrition and Food Services Care Plan updated**

Staff signature_____ Date:_____