# PATIENT FOOD AUTHORIZATION FORM

**(To be completed by Nursing Staff or Physician)**

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| **Patient Name:** | | **Room No.** | |
| **Patient Number:** | | **Date Ordered:** | |

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| [ ] Check here if patient is postpartum at OB ward. **Only** physician approval is required. Dietary Review and Instructions **are not** required. | |
| **Attending Physician**: | |
| **Diet Order**: | |
| **Dates of which outside food is authorized**:<br>[ ] Throughout hospitalization [ ] From ____/____/____ to ____/____/____ | |
| **Justification:** | |
| Nurse (Print & Sign): | Date: |

**DIETARY REVIEW & INSTRUCTIONS (To be completed by Clinical Dietetic Staff)**

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| **Date/Time Received:** | Date/Time Patient Visit: |
| **RD/DTR Name:** | |

[ ] **Justification reviewed**

[ ] **Request for outside food honored**

- [ ] Diet prescription & instructions discussed with patient/family/watcher
- [ ] Proper food preparation methods discussed
- [ ] Proper holding & serving food temperatures for hot & cold foods discussed
- [ ] Individual serving sizes (patient consumption only) discussed
- [ ] Appropriate food containers discussed
- [ ] Delivery of outside food (Security check-in, timing of meals) discussed
- [ ] Disposal of leftovers to be stored in room) discussed
- [ ] Risks of food-borne illness associated with outside food discussed
- [ ] Suspension of food trays or selected food items discussed, if applicable
- [ ] Compliance monitors discussed
- [ ] Other(s): _____

[ ] **Request for outside food canceled; concerns handled by Dietary**

- [ ] Special food request is available in Dietary → Request honored/provided by Dietary
- [ ] Meal/Food substitution requested → Request honored/provided by Dietary
- [ ] Special method of food preparation requested → Request honored by Dietary
- [ ] Support person(s) unable to provide food that complies with diet prescription
- [ ] Other(s): _____

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|---|---|
| **Patient's** signature: | Date: |
| **Support person's** signature: | Date: |

**REQUIRED SIGNATURES (for approval)**

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| **Approval by Attending Physician of postpartum patient ONLY**<br>Physician Signature: | Date: |
| **Approval for ALL hospital patients**<br>Dietician/Dietetic Technician: | Date: |

## Patient Food Authorization Form

PATIENT ID LABEL

GMHA FORM# 0212 STOCK # 990212
FORM REVISED: 10/2010
APPROVED DATE: EMC 3/2010, MEC 3/2010, HIMC 10/2010

**Original: Patient's Chart → cc: Dietary, Security, Patient/Support Person**