# PATIENT FOOD AUTHORIZATION FORM

(To be completed by Nursing Staff or Physician)

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Room No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Number:</td>
<td>Date Ordered:</td>
</tr>
</tbody>
</table>

[ ] 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:**

[ ] Throughout hospitalization   [ ] From _____/_____/____ to _____/_____/____

**Justification:**

Nurse (Print & Sign): Date:

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

<table>
<thead>
<tr>
<th>Date/Time Received:</th>
<th>Date/Time Patient Visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RD/DTR Name:</strong></td>
<td></td>
</tr>
</tbody>
</table>

[ ] 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): __________________________________________________________________________

**Patient’s signature:** Date:

**Support person’s signature:** Date:

**REQUIRED SIGNATURES (for approval)**

**Approval by Attending Physician of postpartum patient ONLY**

Physician Signature: Date:

**Approval for ALL hospital patients**

Dietician/Dietetic Technician: Date: