DINING PLAN

Name: **Revised Date:**

CHOKING RISK: yes/no **DYSPHAGIA DIAGNOSIS: yes/no**
FOOD ALLERGIES:

DIET RESTRICTION/SPECIAL DIET:

FOOD TEXTURE:

-

FLUID TEXTURE:

-
-

SUPPLEMENTS:

-
-

EATING/SPECIAL INSTRUCTIONS:

-
-

SNACKS:

-
-

SPECIFIC SKILLS TO MAINTAIN/ACQUIRE:

-
-

COMMUNICATION

-
-

Pictures of adaptive equipment should be placed here.

Use a digital camera, polaroid etc…
Electronically attach or tape polaroid picture

Pictures of individual in his/her appropriate eating position and staff position during meals (if assistance is needed) should be placed here.

TRIGGERS To Notify *(Nurse, Lead Staff, House Manager,Supervisor)* Staff:

• Coughing with signs of struggle (watery eyes, drooling, facial redness) • Wet Vocal Quality • Vomiting	• Sudden change in breathing • Watery eyes • Weight loss/gain of 5 lbs. in a month.

IF APPROPRIATE EQUIPMENT IS NOT AVAILABLE OR YOU ARE UNSURE OF HOW TO IMPLEMENT THIS PLAN CONTACT YOUR SUPERVISOR