TENNESSEE DEPARTMENT OF CORRECTION

THERAPEUTIC DIET ORDER

INSTITUTION: _____ **LOCATION:** _____

NAME: _____ NUMBER: _____ DATE OF BIRTH: _____

ALLERGIES: _____

POTENTIAL FOOD/DRUG INTERACTION: _____

TYPE OF REQUEST: ☐ New ☐ Renewal ☐ Change ☐ Cancel

TYPE OF DIET:

☐ Clear Liquid (3 days only) ☐ Full Liquid ☐ Mechanical Soft ☐ Bland ☐ Renal (includes HS snack)

☐ Pureed ☐ Finger Food ☐ Snacks - ☐ High-Fiber ☐ Hepatic-includes HS snack

☐ Low-fat/Low Cholesterol, No Added Salt ☐ AM ☐ PM ☐ HS ☐ Prenatal Diet

☐ Moderate Calorie/Carbohydrate (ADA) with No Added Salt (includes 3 meals with HS Snack)

DURATION: _____Days START DATE: _____ STOP DATE: _____

SIGNATURE: _____ DATE: _____

Health Care Provider/Title

THIS SPECIAL DIET HAS BEEN EXPLAINED TO ME AND I UNDERSTAND I WILL BE CHARGED THE COST OF ANY MODIFIED MEAL I FAIL TO PICK UP.

_____ _____

Inmate's Signature Date

THIS SECTION TO BE COMPLETED BY DIETARY SERVICES

DIETARY SERVICES (Comments compliance/noncompliance, i.e., failure to pick up diet, diet refusal, irregular use, etc.):

Diet Compliance/Noncompliance: (Circle Letter to Indicate Noncompliance)

B = Breakfast **L** = Lunch **D** = Dinner

MONTH _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

SIGNATURE: _____ DATE: _____

Authorized Food Service Representative/Title

CR-1798 (Rev. 10-11) White-Inmate(s) Health Record (Upon Completion by Dietary) Canary-Dietary Services RDA 1458

Pink-Inmate Goldenrod-Inmate Health Record (Until Return of Completed Original)