Facility:	Address:
Phone:	Fax:

DIET CLARIFICATION

Resident's Name:	**Physician:**

Your patient/resident resides in an assisted living community. Please check the diet(s) for your patient/resident to follow:

__________ **No dietary restrictions currently**

__________ No added salt

__________ Controlled or consistent carbohydrates (for diabetic management)

__________ Vegetarian

__________ Gluten - Free

__________ Altered texture (specify) ______________________

__________ May consume alcoholic beverages

Date:

____

Physician Signature