SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

INPATIENT DIET ORDER

DATE: _____ **TIME:** _____

PATIENT NAME: _____ **ROOM #:**_____

Check Appropriate Box for Diet:

❒ **NPO** ❒ **Regular** ❒ **Calorie Controlled (based on 1800 Diabetic Diet)** ❒ **Fat Controlled**
❒ **Sodium Controlled** ❒ **Renal** ❒ **Clear Liquid** ❒ **Full Liquid** ❒ **Mechanical Soft / Puree**
❒ **Kosher** ❒ **Pediatric** ❒ **Dialysis**

Please Specify Other Diet Restrictions (modifications will be made accordingly):_____
_____
_____
_____
_____

Oral Nutritional Supplement (consult dietitian for recommendation and details or see Formulary for product details): Check Box and specify Quantity and Frequency

❒ **Ensure Plus** ❒ **Glucerna Shake** ❒ **Enlive** ❒ **Pulmocare** ❒ **Vital Jr.** ❒ **Juven**
❒ **Ensure Pudding** ❒ **Nepro** ❒ **Suplena** ❒ **Pediasure** ❒ **Benecalorie** ❒ **Benefiber**
❒ **Beneprotein** ❒ **MCT OIL** ❒ **Prostat:** _____
_____
_____
_____

Enteral Diet Order: (Consult dietitian and see Formulary for complete list of products and details)
Check Box to Specify Enteral Formula:
❒ **Jevity 1.2 Cal** ❒ **Promote** ❒ **Vital Jr.**
❒ **Glucerna 1.2** ❒ **Perative** ❒ **Optimental** ❒ **Pivot 1.5 Cal** ❒ **Pulmocare** ❒ **Oxepa**
❒ **Nepro** ❒ **Suplena** ❒ **Pediasure**

Frequency of Feeding:_____ **Total Volume/Day**_____

Other Dietary Recommendations: _____
_____
_____
_____

Physician's Name: _____ Signature: _____ Date: _____

Nurse's Name: _____ Signature: _____ Date: _____