St 1 Cr 7

INTERFAITH HOUSE

NUTRITION SERVICES

Dietary Need Request

Date of Intake: _____

Resident Name: _____ Room #_____

Dietary needs (check all that apply; if no special needs, check general diet only):

_____ General Diet

_____ Diabetic

_____ Low cholesterol

_____ Low Salt/Sodium

_____ Renal/Dialysis

_____ Lactose Intolerant

_____ Liquid Diet

_____ Calorie: _____

_____ Vegetarian / Vegan

_____ Other_____

Food Allergies: _____

Religious Food Restrictions: _____

_____ _____

Resident Signature Date

Please put in the Dietary Services Manager mailbox.

Revised March 2014