

Food and Fluid Record

Name: _____

Diet Type: _____

Date: _____

Meal	Description of Food	Full	3/4	1/2	1/4	0	Time	Description of Fluids	Amount In	Amount Out	Total
Breakfast & midmorning											
	Snack:										

Action taken if < 1/2 of meal eaten: _____

Signature: _____

Lunch & afternoon											
	Snack:										

Action taken if < 1/2 of meal eaten: _____

Signature: _____

Supper & evening time											
	Snack:										

Action taken if < 1/2 of meal eaten: _____

Signature: _____

Please document all dietary intake including snacks/nourishing drinks including milkshakes, smoothies, cup of soups, state whether drinks are with sugar/milk/fortified milk/ice cream/nutritional supplements (if they are prescribed).
To ensure accuracy please complete the above as fully as possible and document when and why meals are declined. Inform senior staff if resident is not eating/drinking.

INFORM SENIOR STAFF IF PATIENT IS NOT EATING / DRINKING