EXTENDED CARE

Waiver for Diet/ Texture- Modified Diet

Resident Name: _____ Medical Record Number: _____

Date of Birth: _____

Physician Name: _____

I _____ understand that my physician has ordered a _____diet as part of my treatment plan. This diet is important to my health and well-being related to my chewing and/or swallowing problems. However, I prefer to make my own food choices and wish to decline to follow the _____diet that is being prescribed. I have been educated on the risks and benefits of following the prescribed diet and accept responsibility for any health conditions that may result from refusal of the diet. My questions about the texture modified diet have been answered by the facility staff. I understand that eating foods or drinking fluids that are not recommended by the doctor and the speech-language pathologist could result in choking, coughing, aspiration, dehydration, malnutrition, pneumonia and/ or death. I release _____ (facility name) of any liability regarding this decision to refuse the recommended diet.

_____ _____

Resident/ responsible party Date

_____

Relationship if other than resident

_____ _____

Facility representative Date

_____ _____

Attending physician notified Date

_____ _____

Physician signature Date