Physician nutrition care communication form

Doctor_____ Date_____ Time_____
Please see nutrition progress note of _____. After completion of a
☐ nutrition assessment or
☐ swallowing evaluation,
the following medical nutrition therapy is recommended.

Option 1: Active nutrition care
☐ **PO management**
☐ Please _____
☐ Please order the following nutrition supplement. _____
☐ Please order the following vitamin(s) q day. _____
☐ Please order a prealbumin _____
☐ **Tube feeding**
☐ Please sign enteral nutrition monitoring orders (see order section).
☐ Please order _____
☐ **Parenteral nutrition**
☐ Peripheral parenteral nutrition (expected support 3–5 days and there is adequate peripheral access)
☐ Central parenteral nutrition (central formula needed, expected support ≥ 5 days, there is inadequate peripheral access or central line is already available)

Option 2: Passive nutrition care
☐ Comfort care (food and fluid as patient desires)

Please call _____ at extension _____ if you would like to discuss the patient's nutrition or swallowing care plan.