

# Food and Fluid Record

Name: \_\_\_\_\_

Diet Type: \_\_\_\_\_

Date: \_\_\_\_\_

Meal	Description of Food	Full	¾	½	¼	0	Time	Description of Fluids	Amount In	Amount Out	Total
Breakfast & midmorning											
Snack:											
Action taken if < ½ of meal eaten:											
Signature:											
Lunch & afternoon											
Snack:											
Action taken if < ½ of meal eaten:											
Signature:											
Supper & evening time											
Snack:											
Action taken if < ½ of meal eaten:											
Signature:							Total				

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**