NAME: D.O.B:

HIGH OAKS - Nutritional Support Plan

RESIDENT Name:			
Likes	**Dislikes**	**Allergies or relevant condition**	**Relevant Comments**
Sensory impairments	**Where likes to eat / at the table / tray on lap etc**	**Behaviours relevant to mealtimes**	**Relevant Comments**
Can the person be left in the kitchen unattended **Yes / No** **If no – describe hazards / issues**	**Does the person have access to snacks / drinks or do they need to be left accessible for the RESIDENT** **Give details:**	**Is there any issue with self induced vomiting after meals? If yes please give guidance on how this is dealt with.** **Are there any dangers to be aware of associated with eating e.g. risk of choking, if yes please give guidance on how this is dealt with.**	**Relevant Comments**

 Plan created: / review date

Comments / Choices made by RESIDENTS:

Who is responsible for purchasing food and beverages?

Example Meals:

Breakfast	Lunch	Dinner	Snacks

The aims and objectives of the nutritional support plan are:

List any treatment of any underlying conditions that have a bearing on nutritional support:

List any treatment of malnutrition with food and/or nutritional supplements:

List relevant information where RESIDENTS are unable to meet their nutritional requirements orally and where they require artificial nutritional support, e.g. enteral or parenteral nutrition:

NAME: D.O.B:

WEIGHT	DATE	INCREASE / DECREASE	WEIGHED BY	NOTES

NB: Weight is checked monthly and should be updated on the plan with the same frequency

If RESIDENT is overweight or obese, include guidelines for weight management:

Risks associated with eating / food/ drinking:

Risk activity	Level of Risk (Include variables)	Control measures

RESIDENT signature or indication that they have been fully involved with the development of this form:

Date:

Name of Person completing form with RESIDENT:

Signature:

Date:

Other people:

In the case of multi disciplinary nutritional support planning please indicate below, who takes the lead, and the contact details of all involved parties, their function and the situations in which COMPANY NAME can contact them.

Name	Function / Position / Job Title	Contact details	When to be contacted

Agreed monitoring and review dates of nutritional intervention and dates for reassessment if RESIDENT is identified as being at nutritional risk:

Date	Type of review / Intervention	Name /s of people involved	Notes