<table>
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<tr>
<th>Date &amp; Time</th>
<th>Medical Nutrition Therapy Order Set</th>
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<td>Contact Clinical Dietitian at ext # 6935 for questions</td>
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1. **Modify Diet Order To:**

   - [ ] Regular
   - [ ] Carb Counting __________
   - [ ] General Healthful
   - [ ] Calorie Controlled __________
   - [ ] Mech Soft
   - [ ] 2 Gram Sodium
   - [ ] NPO
   - [ ] Puree
   - [ ] GI Soft
   - [ ] 1.5 Gram Sodium
   - [ ] Other: ____________________________

2. **Oral Nutrition Supplement:**

   - [ ] Ensure Enlive
   - [ ] Glucerna
   - [ ] ProSource No Carb
   - [ ] Ensure Clear
   - [ ] Nepro
   - [ ] Suplena
   - [ ] Juven

   Frequency: [ ] 1x/day [ ] Daily [ ] BID [ ] TID [ ] 4x/day

3. **Enteral Nutrition:**

   - [ ] Glucerna 1.2
   - [ ] Glucerna 1.5
   - [ ] Glucerna 1.5 TID
   - [ ] Two Cal HN
   - [ ] Other: ____________________________
   - [ ] Vital AF 1.2
   - [ ] Nepro with Carb Steady
   - [ ] Oxepa
   - [ ] Suplena with Carb Steady
   - [ ] Jevity 1.2
   - [ ] Vital 1.5
   - [ ] Jevity 1.5

Access:

   - [ ] Nasogastric tube
   - [ ] PEG
   - [ ] Oralgastric tube
   - [ ] Jejunostomy
   - [ ] Other: ____________________________

   - [ ] Begin Formula at full strength ____mL/hr and increase rate by ____ml every ____ hours until goal rate of ____ml/hr is reached.
   - [ ] Continuous feeding: Rate of _________mL per hour.
   - [ ] Begin Bolus feedings at ______ml ____ times per day. Check residuals before each bolus feeding.
   - [ ] TID [ ] 6x/Day
   - [ ] Flushes: __________________________________________________________________________
   - [ ] Other: __________________________________________________________________________

   - [ ] Notify MD of any nausea, vomiting, and/or residuals >500ml.
   - [ ] Keep patient head elevated 30-45 degrees.
   - [ ] Check residuals each shift and document. If GRV is >250ml after a 2nd check, consider promotility agent per MD.
   - [ ] Hold TF for GRV >500ml.

4. **Nutrition Assessment/Reassessment:**

   - [ ] Obtain and record patient Height
   - [ ] Obtain and record patient Weight
   - [ ] Start Calorie Count: [ ] 24-hr [ ] 48-hr [ ] 72-hr
   - [ ] Labs: ____________________________

5. **Other:**

   - [ ] Discontinue: ____________________________
   - [ ] Additional Instructions: ____________________________

   Date [ ] Time [ ] Per MNT Protocol

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DIETITIAN ORDERS

BOTTOM EDGE OF PATIENT LABEL

REV 05/16; SD40-3