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| **PATIENT NAME / NUMBER:** |

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| **NORMAL FLUIDS**  **IDDSI LEVEL 0** | |
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| **DIET** |
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| **DISCONTINUE IF:**   * COUGHING / CHOKING. * INCREASED WETNESS OF BREATH. * SHOWING FATIGUE. * WET / GURGLY VOICE. * SIGNS OF DISTRESS. | **CLIENT MUST BE:**   * AWAKE AND ALERT. * POSITIONED FULLY UPRIGHT. * CHECK MOUTH IS CLEAR AFTER   ORAL INTAKE. |
| **DATE:** | **CONTACT NAME AND NUMBER:** |

