THE DIABETIC DIET

PURPOSE:

To provide a nutritionally adequate diet that will help in controlling blood sugar levels.

POSSIBLE PROBLEMS WITH FAILURE TO FOLLOW PRESCRIBED DIET:

1. Increased risk for too high or too low blood sugar levels.
2. Increased risk for heart disease.
3. Increased risk for kidney disease.
4. Increased risk for nerve damage leading to loss of toes, feet, etc.

MODIFIED DIET WAIVER FORM
GEORGIA DEPARTMENT OF CORRECTIONS

OFFENDER'S NAME:	
I.D. NUMBER:	
DIET ORDER:	
BEGINNING DATE:	
ENDING DATE:	

I, _____, understand that failure to pick up my above prescribed diet six (6) meals a week and/or 15 meals a month may result in the cancellation of the prescribed diet. I have been instructed and understand the possible complications that may arise due to non-compliance of my prescribed diet.

WITNESS:	OFFENDER'S NAME:
DATE:	DATE:

*** Please file in the offender's medical record.**

Retention Schedule: Upon completion, this form shall be kept locally for one (1) year in the Food Service Office, then stored locally for five (5) years in an inactive file and destroyed.

THE HYPOGLYCEMIC DIET

PURPOSE:

To provide a nutritionally adequate diet that helps to prevent symptoms of low blood sugar.

POSSIBLE PROBLEMS WITH FAILURE TO FOLLOW PRESCRIBED DIET:

1. Increased risk for experiencing symptoms of low blood sugar such as: sweating, fast heartbeat, weakness, and hunger.

MODIFIED DIET WAIVER FORM
GEORGIA DEPARTMENT OF CORRECTIONS

OFFENDER'S NAME:	
I.D. NUMBER:	
DIET ORDER:	
BEGINNING DATE:	
ENDING DATE:	

I, _____, understand that failure to pick up my above prescribed diet six (6) meals a week and/or 15 meals a month may result in the cancellation of the prescribed diet. I have been instructed and understand the possible complications that may arise due to non-compliance of my prescribed diet.

WITNESS:	OFFENDER'S NAME:
DATE:	DATE:

*** Please file in the offender's medical record.**

Retention Schedule: Upon completion, this form shall be kept locally for one (1) year in the Food Service Office, then stored locally for five (5) years in an inactive file and destroyed.

THE LOW FAT LOW CHOLESTEROL DIET

PURPOSE:

To provide a nutritionally adequate diet low in total fat, saturated fat, and cholesterol.

POSSIBLE PROBLEMS WITH FAILURE TO FOLLOW PRESCRIBED DIET:

1. Increased risk for heart disease.
2. Increased risk for weight gain which may lead to high blood pressure, diabetes, and heart disease.

MODIFIED DIET WAIVER FORM
GEORGIA DEPARTMENT OF CORRECTIONS

OFFENDER'S NAME:	
I.D. NUMBER:	
DIET ORDER:	
BEGINNING DATE:	
ENDING DATE:	

I, _____, understand that failure to pick up my above prescribed diet six (6) meals a week and/or 15 meals a month may result in the cancellation of the prescribed diet. I have been instructed and understand the possible complications that may arise due to non-compliance of my prescribed diet.

WITNESS:	OFFENDER'S NAME:
DATE:	DATE:

*** Please file in the offender's medical record.**

Retention Schedule: Upon completion, this form shall be kept locally for one (1) year in the Food Service Office, then stored locally for five (5) years in an inactive file and destroyed.

THE MECHANICAL SOFT/SOFT DIET

PURPOSE:

To provide a nutritionally adequate diet of foods that are easily chewed or swallowed. Foods will also be soft in texture and lower in fiber. This diet is useful for those with mild intestinal problems or recent dental work and/or no teeth.

POSSIBLE PROBLEMS WITH FAILURE TO FOLLOW PRESCRIBED DIET:

1. May have difficulty chewing or swallowing certain foods.
2. May have difficulty digesting certain foods.

MODIFIED DIET WAIVER FORM
GEORGIA DEPARTMENT OF CORRECTIONS

OFFENDER'S NAME:	
I.D. NUMBER:	
DIET ORDER:	
BEGINNING DATE:	
ENDING DATE:	

I, _____, understand that failure to pick up my above prescribed diet six (6) meals a week and/or 15 meals a month may result in the cancellation of the prescribed diet. I have been instructed and understand the possible complications that may arise due to non-compliance of my prescribed diet.

WITNESS:	OFFENDER'S NAME:
DATE:	DATE:

*** Please file in the offender's medical record.**

Retention Schedule: Upon completion, this form shall be kept locally for one (1) year in the Food Service Office, then stored locally for five (5) years in an inactive file and destroyed.

THE LOW SODIUM DIET

PURPOSE:
To provide a nutritionally adequate diet restricted in sodium which may help reduce high blood pressure and reduce build-up of fluid in the body.

POSSIBLE PROBLEMS ITH FAILURE TO FOLLOW PRESCRIBED DIET:

1. May worsen genetic risk for high blood pressure.
   High blood pressure can increase risk for stroke.
2. May worsen build-up of fluid in the body.
3. May worsen conditions of congestive heart failure.

MODIFIED DIET WAIVER FORM
GEORGIA DEPARTMENT OF CORRECTIONS

OFFENDER'S NAME:	
I.D. NUMBER:	
DIET ORDER:	
BEGINNING DATE:	
ENDING DATE:	

I, _____, understand that failure to pick up my above prescribed diet six (6) meals a week and/or 15 meals a month may result in the cancellation of the prescribed diet. I have been instructed and understand the possible complications that may arise due to non-compliance of my prescribed diet.

WITNESS:	OFFENDER'S NAME:
DATE:	DATE:

*** Please file in the offender's medical record.**

Retention Schedule: Upon completion, this form shall be kept locally for one (1) year in the Food Service Office, then stored locally for five (5) years in an inactive file and destroyed.

THE WEIGHT REDUCTION DIET

PURPOSE:

To provide a nutritionally adequate diet that will produce weight loss at a reasonable rate. **To be truly effective, diet should be combined with an exercise program.

POSSIBLE PROBLEMS WITH FAILURE TO FOLLOW PRESCRIBED DIET:

1. Obesity is associated with increased risk for high blood pressure, heart disease, diabetes, and certain types of cancer.

MODIFIED DIET WAIVER FORM
GEORGIA DEPARTMENT OF CORRECTIONS

OFFENDER'S NAME:	
I.D. NUMBER:	
DIET ORDER:	
BEGINNING DATE:	
ENDING DATE:	

I, _____, understand that failure to pick up my above prescribed diet six (6) meals a week and/or 15 meals a month may result in the cancellation of the prescribed diet. I have been instructed and understand the possible complications that may arise due to non-compliance of my prescribed diet.

WITNESS:	OFFENDER'S NAME:
DATE:	DATE:

*** Please file in the offender's medical record.**

Retention Schedule: Upon completion, this form shall be kept locally for one (1) year in the Food Service Office, then stored locally for five (5) years in an inactive file and destroyed.