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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:** |

