ORANGE COUNTY OFFICE FOR THE AGING SENIOR DINING PROGRAM

NUTRITION COUNSELING DOCUMENTATION FOLLOWING INITIAL ASSESSMENT

CLIENT NAME_____DATE OF BIRTH_____

OFA SDP STATUS: HDM _____CONGREGATE _____ NON-PARTICIPANT OF MEAL SERVICES_____

ADDRESS: _____

CLIENT PHONE:_____ OR OTHER CONTACT: _____

INITIAL RD ASSESSMENT DATE: _____ PREVIOUS RD FOLLOW-UP DATES: _____

DATE OF THIS FOLLOW-UP VISIT: _____WHERE SEEN:_____

CURRENT CONCERNS:_____

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NUTRITION INFORMATION PROVIDED:_____

_____

FOLLOW-UP NEEDED: _____

_____

REFERRALS NEEDED: _____

OTHER RD NOTES:_____

_____

RD SIGNATURE