OKLAHOMA DEPARTMENT OF CORRECTIONS
MEDICAL DIET REQUEST

Date: ___________________                                      Renewal Date: ___________ (at least annually)

Medical Diet (check one):

☐ Mechanical Soft
☐ Diet for Health
☐ Other Medical Diet:
  ☐ Renal Non-Dialysis ☐ Renal Dialysis
  ☐ Low Protein ☐ Clear Liquid ☐ Full Liquid
  ☐ Clinically Verified Food Allergy

  o Source of verification

  o Reviewed by

(Food preferences or food intolerance may be addressed through a Request to Staff to Food Services)

Snacks (check one)

☐ PM Diabetic Snack
☐ OB Snack
☐ Hypercaloric Snack
☐ Medication Snack x __________ per day

_______________________________________________ Date: ________________________
Qualified HealthCare Professional

_______________________________________________     _______ Change     ______ Cancel
Offender Housing Assignment

Name: ________________________________ DOC #: _______________ Diet: ____________