Hospital Patient Food Delivery Consent Form

Patient Name

Room Number

Date of Birth

Admission Date

Dietary Restrictions / Allergies

Restaurant / Food Source

Food Description

☐ I understand that external food may not meet hospital dietary or safety standards.

☐ I accept responsibility for any risks or adverse events related to the consumption of external food.

Patient/Representative Consent

Signature

Date

Printed Name

Staff Use Only

Staff Name

Signature

Date