Directions:

Make sure to fill in

1. **Your Name**
2. **The name of your Surgeon and Surgical Clinic**
3. **Print and Laminate**

SPECIAL MEDICAL DIET REQUEST

Patient Name: _____

The above-named patient has undergone gastric surgery that reduces the size of their stomach therefore reducing the portion sizes they can eat. Please allow them to purchase smaller portions or make a selection from the child/senior menu.

Surgeon's Information:

Name: _____Phone: _____

Thank you for your cooperation.