Hospital Center

NUTRITION ASSESSMENT FORM

DATE: _____ TIME: _____

Diet history obtained ☐ Yes ☐ No Special diet PTA: ☐ Yes ☐ No Specify: _____

Food Allergies: _____

Issues affecting nutrient intake: ☐ Decreased appetite ☐ Anorexia ☐ Dysphagia ☐ Odynophagia
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Mouth Sores
☐ Edentulous/poor dentition ☐ None ☐ Other _____

Weight Change: ☐ Yes ☐ No If yes: ☐ Gain ☐ Loss Amount: _____ lb/kg Time Frame: _____ wks/mos/yrs

Unable to obtain subjective information due to _____

_____ y o M / F Diagnosis _____

Pertinent PMH/PSH: _____

Treatments/Co-Existing Problems: _____

Diet Rx: _____

Ht: _____ Wt: _____ IBW/Desirable Wt: _____ % IBW/Desirable Wt: _____

BMI: _____ Usual BW: _____ % Usual BW: _____ % Wt. Change: _____

Nutritionally Significant Meds: _____

Nutritionally Significant Labs: _____

NUTRITIONAL EVALUATION:

Current diet ☐ appropriate ☐ not appropriate due to _____

History/patient information reveals:

☐ adequate/inadequate knowledge of prescribed diet ☐ compliance/non-compliance to prescribed diet

☐ adequate/inadequate intake prior to admission

Physical assessment: _____

Estimated nutrient requirements: Kcal _____ day Pro _____ g/day For: ☐ maintenance ☐ gain ☐ loss
(_____ kcal/_____kg) (_____ grams/_____kg) Fluid needs: _____ mL/d

Summary and nutrition risk assessment:

☐ able to meet kcal/pro needs ☐ no evidence of malnutrition ☐ low risk
☐ unable to meet kcal/pro needs ☐ mild malnutrition _____ ☐ moderate risk
☐ unable to assess ☐ moderate malnutrition _____ ☐ high risk
☐ insufficient data ☐ severe malnutrition _____

Nutrition related Issues: _____

NUTRITION CARE PLAN/RECOMMENDATIONS:

☐ Continue Current Diet ☐ Change/advance Diet to: _____

☐ Order nutrition supplement. _____

☐ Change / Initiate Enteral Feeding: Formula: _____ Via: _____

Start at: _____ mL/hr _____ hrs/day _____ strength

Target Rate: _____ mL/hr Increase rate by _____ mL Q_____ hr

Additional Fluid / Flushes: _____

Provides. Kcal: _____ kcal/ d Protein: _____ g/d Total Free H2O: _____ mL/d

Other: _____

☐ Change / Initiate TPN PPN: _____

Provides: Kcal: _____ Protein: _____ g Fluid: _____ mL Other: _____ / d

☐ Order vitamin or mineral supplementation. _____

☐ Obtain weights _____

☐ Nutrition education provided/not provided due to _____

☐ **See Interdisciplinary Patient Education Form for Further Documentation**

☐ Other: _____

Signature: _____ Beeper: _____

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