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/ys

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 Wt: __________ % Usual Wt: __________ % 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) (____ g/nm/____ 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 O __________ 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: ______________________ Date: ____________ Beeper: ______________________