DIETARY HISTORY AND INITIAL SCREENING

❒ **ADMISSION** ❒ **SIGNIFICANT CHANGE** ❒ **ANNUAL**

HT_______________ WT_______________ DATE_______________
USUAL OR GOAL WEIGHT_______________ ADJUSTED WT FOR AMPUTATION_______________
COMPLAINT OR PRIOR WEIGHT LOSS__________ AMOUNT__________ OVER__________ MONTHS
WEIGHT HISTORY IN LAST 12 MONTHS_______________ BMI_______________
DIET ORDER/TF ORDER_______________ SUPPLEMENT ORDERS_______________
MEAL CONSUMPTION REPORTED/OBSERVED: BREAKFAST__________ LUNCH__________
DINNER__________ SNACKS__________

POTENTIAL RISK FACTORS/REFERRAL CRITERIA FOR NEW ADMISSION OR SIGNIFICANT CHANGE:

1. ❒ OBSERVED INTAKE <50% 2 OF 3 MEALS
2. ❒ BMI <19
3. ❒ TF/NPO STATUS
4. ❒ DX DYSPHAGIA/THICKENED LIQUIDS NOT PREVIOUSLY REFERRED TO RD
5. ❒ WOUND OR PU (STAGE II OR HIGHER) NOT PREVIOUSLY ASSESSED BY RD
6. ❒ DX DEHYDRATION/PO FL INTAKE OBSERVED <1000 ML NOT PREVIOUSLY ASSESSED BY RD

REFER TO RD VIA FAX/ON CALL
❒ MORE THAN 1 CRITERIA CHECKED
❒ #3, #4, #5 AND #6 CHECKED

❒ NO POTENTIAL RISK FACTORS OR REFERRAL CRITERIA AT TIME OF SCREENING

DATE_______________ REFERRED BY_______________

CHEWING/SWALLOWING

❒ Own Teeth/Good Condition/No Complaints
❒ Few/Broken/Poor Condition of Teeth/Mouth Sore
❒ Dentures
❒ Refuses to Wear Dentures
❒ Mechanically Alternated Diet Required
Why?_______________
Type_______________
❒ Dysphagia Diagnosis
❒ Loss of Liquid From Mouth When Eating
❒ Holding Food in Mouth/Residual Remains After Eating
❒ Coughing or Choking During Meals or Medication Consumption
❒ Complaining of Pain or Difficulty in Swallowing

DINING NEEDS

❒ Independent/No Assistance Required
❒ Self w/Set-Up
❒ Encourage/Staff Assist
❒ Adaptive Device
Type_______________
❒ Change in Ability to Feed Self
Why?_______________
❒ Supervised Dining
❒ Restorative Dining
❒ Therapeutic Diet Supervision

RESIDENT INTERVIEW FOR DINING PREFERENCES

Beverages_______________

Likes_______________

____

Dislikes_______________

____

Snack/Supplement Preferred_______________ Time of Day_______________

Reported Appetite_______________

Portion Size Preference_______________

Completed by_______________ Date_______________

LAST NAME__________ FIRST NAME__________ PHYSICIAN__________ ROOM #_____

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RD ASSESSMENT

❒ **ANNUAL** ❒ **ADMISSION** ❒ **UPDATED FOR SIGNIFICANT CHANGE** **DATE**______________________

MEDICATIONS USED

❒ Diuretics (potential for altered electrolytes)
❒ Psychotropics (potential for intake, dry mouth)
❒ Glycosides/Insulin (potential for glucose)
❒ Laxatives (potential for altered electrolytes)
❒ Anticonvulsants (potential change in taste)
❒ Other

COMMENTS (SIGNS/SYMPTOMS/SIDE EFFECTS)

DATE					DATE					
GLUCOSE					CHOL					
B.U.N.					TRIG					
CREATININE					HGB					
Na					HCT					
K					IRON					
ALBUMIN					CAL	VIT D				
TP					OTHER					

RD EVALUATION OF POTENTIAL RISK FACTORS/SCREENING FACTORS FROM MDS

WEIGHT LOSS

❒ Below Desired Weight Range
❒ Poor Intake/Potential <75%
❒ HX of Weight Loss
❒ Tube Feeding
❒ DX of Cancer
❒ DX of Malnutrition
❒ DX of Dementia/Alzheimer's
❒ Unusual/Excessive Preferences

PRESSURE ULCERS

❒ Recent Fracture/Trauma/Surgery
❒ Diabetes
❒ DX of Malnutrition
❒ Incontinence
❒ Limited Mobility
❒ Assessed Risk
❒ Current Pressure Ulcer
❒ Non-pressure Ulcer

DEHYDRATION

❒ U.T.I./Diuretics/Multiple Meds
❒ Full or Clear Liquid Diet
❒ Difficulty Swallowing/Thickened Liquids
❒ Kidney Disease/Dialysis/FL Restriction
❒ Ostomy
❒ Diabetes
❒ DX or HX of Dehydration
❒ Abnormal Labs/BUN/CR/NA
❒ Fever/Nausea/Vomiting

ESTIMATED NUTRITIONAL NEEDS - (CIRCLE FACTOR USED)

ENERGY
wt/kg ______ x 25 (wt moderate) 28 (maintenance) 30 (wt increase) 35 (high level support) = _______ total cal

Other______________________________ Reason______________________________

PROTEIN
wk/kg ______ x 1.0 (normal) 1.2 (stg II PU, ↑ needs) 1.3 (stg III PU, ↑ needs) 1.4 (stg IV PU or multiple PU) = _______ gm protn
1.5 (nonhealing PU or > 2 PU)

Other______________________________ Reason______________________________

FLUID
wt/kg ______ x 25 (renal/edema end-stage CHF) 30 (normal) 35 (↑ pro diet, fluid losses) = _______ total cc

Other______________________________ Reason______________________________

NUTRITION PROBLEM: #1______________________________ #2______________________________

EVALUATION OF NEEDS/RECOMMENDATIONS/INTERVENTIONS FOR NUTRITION CARE:____________________

Completed by______________________________ Date____________________

Revision______________________________ Date____________________

LAST NAME__________________ FIRST NAME__________________ PHYSICIAN__________________ ROOM #_______

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