HEALTH TECHNOLOGIES, INC.
Consulting Dietitians, Menu Systems & Software

Facility New Admission/Change in Status RD Fax Referral Form

Guideline: All New Admission/Change in Status Fax Referrals will be sent to the Registered Dietitian (RD) for high risk residents that need to be evaluated by a RD prior to the RD's next visit.

Procedure: **The following information will be supplied to the Registered Dietitian**

Confidential HIPPA Protected Information

From:_____ Date:_____ Return Fax #:_____

Residents are seen within 72 hours after admission, or sooner based on the resident's nutrition risk status or needs. If any of the following factors are present at admission or develop since the last RD consult and not previously addressed at the last consult, refer to the Health Technologies, Inc. Dietitian-On-Call or Facility RD. The RD will respond within 24 hours with a return initial assessment and recommendations. This form is placed in the health record and in the nutrition care book for review by the RD for follow-up at the next regularly scheduled consultation. Refer a resident to the RD if there is a history of weight loss in prior placement, intake less than 50% of most meals, stage II or greater pressure ulcer or tube feeding.

If a fax assessment is required complete the information below from the health record and fax to Health Technologies, Inc. at 314-423-9825, or contact your RD.

Nutrition screen date: _____ Date referral sent: _____

Patient/Resident Name: _____ Health record Number: _____

Diagnosis: _____

Diet Order: _____ Supplement Order: _____

HT: _____ WT: _____ Date of WT: _____

WT History: _____

% Intake in Past 24 to 48 hours: _____

Skin: _____ Intact: _____ Open Area: _____ Stage: _____

Comments: _____

Date: _____ Laboratory/Hematology: _____ Hgb _____Hct ___

Date: _____ Laboratory/Chemistry: _____ Na+ _____ K+ _____

_____ BUN _____ Creatinine _____ GFR _____ Gluc _____ Calcium _____

_____ Total Protein _____ Albumin

Other:_____

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Facility New Admission/Change in Status RD Fax Referral Form (Continued)

Patient/Resident Name: _____ Health record Number: _____

Medications: (or send copy of POS): _____

_____

_____

Registered Dietitian Evaluation and Assessment

Estimated Needs:

_____ kcal/kg X _____ kg ABW= _____ Kcal _____ gm Pro/kg X _____ kg ABW = _____ gm Pro _____ cc FL/kg X _____ kg ABW= _____ cc Fluids per 24 hours.

Nutrition Problem
#1_____

Related to _____ as evidenced by _____

Nutrition Problem
#2_____

Related to _____ as evidenced by _____

Please start following Interventions: (Check all to add and indicate amount in cups or ounces)

_____ House supplement _____ times daily _____ with meals _____ between meals

_____ Add to daily menu selection: _____ milk (whole, 2%, skim) (B, L, S) _____ juice (B, L, S)

_____ pudding (L, S) ____ ice cream (L, S) _____ Other :_____ (B, L, S)

_____ MD order for MVI w/mineral _____ Other: _____

Monitor:

_____ Wt- _____

_____ Skin- _____

_____ Intake- _____

Signed: _____ Date:_____ Call w/questions: _____