Medical Nutrition Therapy Assessment ICF-ID

Name **Residence** **Physician** **Gender** M / F **DOB** **Age**

Assessment Type: Initial / Readmission / Yearly

NUTRITION ASSESSMENT (Problems/Etiology/Signs & Symptoms) **Attends workshop: Yes No**

Ht (inches)

Wt (#)/(Date)

UBW (#)

DBW (#)

Adj. BW (#)(Amputation)

BMI _____

- □ <18.5 Underweight
- □ 19-24.9 Normal Weight
- □ 25-29.9 Overweight
- □ ≥30 Obesity I
- □ 35-39.9 Obesity II
- □ ≥40 Extreme Obesity III

Weight Changes

Wt (#)/(Date) _____ ( ) ↑ ↓ 5% in 1 mo

Wt (#)/(Date) _____ ( ) ↑ ↓ 7.5% in 3 mo

Wt (#)/(Date) _____ ( ) ↑ ↓ 10% in 6 mo

Planned Weight Change? Y / N **Comments:**

Diet Order Reg / Mech Soft / Puree / Other

Food allergies / Intolerances

Adaptive Eating Device

Oral Nutrition Supplement / Snacks

Fluid Restriction

Intake of Food/Fluid Adequate to meet estimated needs? Y / N

Alternate Feeding Orders PPN/ TPN/ IV / Tube feeding (including flush orders)

_____mL Formula = _____ Kcals ____ g protein, ____% RDI (_____mL FF + _____ mL flush) = _____ Total mL Fluids

Appropriate Y / N **Tolerated** Y / N **Changes Needed** Y / N **Comments**

Communication Alert / Confused / Unable to communicate

Medication Interactions

Antibiotics Cardiac Meds Diuretics Laxatives Psychotropics

New Meds / Other:

Treatments

Chemo / Radiation / Wound VAC / Other:

Labs (Date _____)

H/H _____ HbA1c _____ BS _____ Na _____ K+ _____

Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr _____

Supplementation by:

Alteration in Nutrition and/or Hydration Status as Evidenced by (Check/Circle all that apply)

- □ Abnormal Labs (Refer to data above)
- □ Altered Taste
- □ Alternate Feeding: TF / IV / TPN
- □ Anemia
- □ Cancer
- □ CVD / CVA / TIA / CHF / HTN
- □ Chewing / Swallowing Problem
- □ Communication Difficulty:
- □ Cultural Food Issues
- □ Dehydration / Risk
- □ Dementia/Cognitive Decline /Depression
- □ Diabetes
- □ Edema
- □ Failure to Thrive
- □ ↑ ↓ Food / Fluid Intake
- □ Fracture:
- □ GI Disorder/Issues:
- □ Hepatic (Liver) Disease
- □ Hunger (Complains of)
- □ Infection / Fever / Sepsis /URI/ UTI
- □ Kidney Disease
- □ Malnutrition / Undernutrition
- □ Mobility Issues:
- □ Neurological / Muscular Disease
- □ Obesity
- □ Pain Affecting Eating___
- □ Pressure Ulcers / Wounds:
- □ Pulmonary Disease
- □ Self Feeding Difficulty
- □ Surgery (Recent):
- □ Terminal Status
- □ Unintended Weight Loss (Significant)
- □ **Other:**

Nutritional Needs Estimation (Based on CBW)

Total Kcal Needs:
Kg Wt X 25 / 30 / 35 +500 cal to gain/ -500 cal to lose

Protein Needs (g):
Kg Wt X 0.8 / 1.0 / 1.25 /1.5

Fluid Needs (mL):
Kg Wt X 25mL/ 30mL/ 35 mL / 1 mL/kcal

Summary

Education Needs:

Nutrition Diagnosis Statement (PES)

Nutrition Prescription Or Intervention

Signature: **Date:**

Medical Nutrition Therapy Re-Assessment/Updates ICF-ID

Name: _____ Physician: _____ Room: _____

Ht	UBW	BMI □<18.5 Underweight □19-24.9 Normal Weight □ 25-29.9 Overweight □ ≥30 Obesity I □35-39.9 Obesity II □≥40 Extreme Obesity III	DOB	Age	M / F

Estimated Nutritional Needs (Based on CBW)

Total Kcalorie Needs	**Protein Needs (gms)**	**Fluid Needs (mL)**	**Dining Needs** Location changes:
Kg Wt X 25 / 30 / 35 + 500 kcal to gain / - 500 kcal to lose	Kg Wt X 1.0 / 1.25 / 1.5	Kg Wt X 25 / 30 / 35 / 1 mL/cal consumed	Rehab dining: Y / N Adaptive equipment: Independent / Tray set up / Supervise / Cue / Assist / Totally Dependent for Eating:

Date _____ *Re-admit / Quarterly / Progress Note / Yearly*	**Date** _____ *Re-admit / Quarterly / Progress Note / Yearly*	**Date** _____ *Re-admit / Quarterly / Progress Note / Yearly*
New Medical Diagnosis	**New Medical Diagnosis**	**New Medical Diagnosis**
Diet Prescription: Reg / Mech Soft / Pureed Other:	**Diet Prescription:** Reg / Mech Soft / Pureed Other:	**Diet Prescription:** Reg / Mech Soft / Pureed Other:
Supplements	**Supplements**	**Supplements**
Food/Fluid Intake Adequate to Meet Needs Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N
Weights: CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _____# _____ # ( ) ↓ ↑ **5% past Mo** _____ # ( ) ↓ ↑ **7.5% past Qtr** _____ # ( ) ↓ ↑ **10% past 6 Mo**
Lab Changes Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr	**Lab Changes** Date:_____ H/H _____ HbA1c _____ BS _____ Na _____ K+ _____ Ca++ _____ Alb _____ Pre-alb _____ BUN _____ Cr
Changes in Care / Condition (Medications, ADLs, physical, diagnosis, etc):	**Changes in Care / Condition** (Medications, ADLs, physical, diagnosis, etc):	**Changes in Care / Condition** (Medications, ADLs, physical, diagnosis, etc):
NUTRITION DIAGNOSIS □Continue previous □Change to:	**NUTRITION DIAGNOSIS** □Continue previous □Change to:	**NUTRITION DIAGNOSIS** □Continue previous □Change to:
NUTRITION PRESCRIPTION/ INTERVENTION □Continue previous □Change to:	**NUTRITION PRESCRIPTION/ INTERVENTION** □Continue previous □Change to:	**NUTRITION PRESCRIPTION/ INTERVENTION** □Continue previous □Change to:
NUTRITION MONITORING Weight / Labs / Skin / Diet	**NUTRITION MONITORING** Weight / Labs / Skin / Diet	**NUTRITION MONITORING** Weight / Labs / Skin / Diet
Comments	**Comments**	**Comments**
Signature:	Signature:	Signature:
Signature:	Signature:	Signature: