Consultant Report from Registered Dietitian Nutritionist/ Nutrition and Dietetic Technician, Registered

Facility Name ______________________________ **Date** _______________
Time in ____________ **Time Out** ____________ **Hours** _______________
Contracted Hours _________ **Add'l Approved Hours** ________ **Next Scheduled Visit** __________

Consultant's Signature/Title ___________________________________

DOCUMENTATION:

__ **See attached recommendations**
__ Pressure injuries/ulcers
__ Significant weight losses/gains
__ Nutritional Assessments/POCs
__ Tube feedings/Parenteral nutrition
__ Quarterly Progress Notes/POC updates
__ MDS+/CAAs
__ Weight audit
__ Follow up on previous recommendations
__ Resident visitation

CONTINUING EDUCATION/OTHER SERVICES:

__ Inservice/Training
__ Menu/Recipe work
__ Recommendations (See narrative)
__ Information provided

MEETINGS OR COMMUNICATIONS:

__ Administrator/Assistant Administrator
__ DON/Assistant DON
__ Dietary Manager/Asst. Dietary Manager/NDTR
__ STNA / LPN / Nursing Staff
__ SLP / OT / PT
__ Physician
__ POC meeting
__ POC Nurse/MDS+ Coordinator

QUALITY IMPROVEMENT:

__ Recommended needs (See narrative)
__ Sanitation inspection (Attached)
__ Meal service observation (Attached)
__ Food preparation observation (Attached)
__ Test tray (Attached)
__ Chart audit/Other QAPIs (Attached)

Other Comments/Findings:

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Consultant Report from Registered Dietitian/ Dietetic Technician Registered

Facility_________________________ **Signature** _________________________

Major Concerns:	Yes	No	Comments:
Weekly			
Meal Rounds:			
Proper Assistance			
Proper Food Temperatures			
Proper Consistency			
Substitutions Offered			
Meal Replacement Offered			
Assistive Devices as Needed			
Dining Room Well Lighted, Adequately Furnished			
Documentation:			
Up to Date			
Monthly			
Meal Preparation:			
Conserve Nutritive Value, Flavor and Appearance			
Recipes Followed			
Puree Food			
Sanitary Conditions:			
Refrigerator and Freezer Temperatures			
Food Handling			
Special Diets			
Sufficient Staff			
Tray Line Service:			
Cards Followed			
Menus Followed			
Food Attractive			
Proper Portion Size			

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Priority Order Documentation

Facility: ____

ROOM	NAME	PI/ PU	Wt. ↓	N/Re- Admit	TF	Wt. ↑	POC	PN	MDS/ CAAs	Comments

Key:

PI/PU - Pressure injury/ulcer
Wt. ↓ - Significant weight loss
N/Re-Admit - New or Re-admit
TF - Tube feeding
Wt. ↑ - Significant weight gain
POC - Plan of care
PN - Progress notes
MDS/CAAs - Minimum Data Set/Care Area Assessment

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Consideration for Nutrition Intervention

To: Doctor ____________________________________

From: ____________________________________

Resident Name: ________________________________ **Room:** ____________

Current Diet Order: ____

Resident is referred for the following reason.

___ Pressure injury/ulcer
___ Weight loss–Significant
___ Malnutrition
___ Tube feeding issues
___ Swallowing difficulty
___ Need for vitamin/mineral supplement
___ Diet change/Needed
___ Weight gain–Significant
___ Poor appetite
___ ______________________________
____

___ Abnormal labs
___ Renal diet
___ Fracture
___ Nausea or vomiting, persistent
___ Edema, severe
___ UTI
___ Diarrhea, persistent
___ Other:
___ ______________________________
___ ______________________________
____

Please consider nutrition intervention:	Approved: Yes / No

____ ____________________
Signature of Doctor **Date**

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Nutrition Recommendations Form

Facility: **Wing:**

Please complete and return to RDN or designee. Thank You!

Name________________________ Room__________ New____ Re-admit____ Update___

Food and Nutrition Service

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Comments:

Manager's Signature/Date:

Nursing

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Comments:

Nursing Signature/Date:

Physician Please Consider

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Name__________________________ Room__________ New____ Re-admit____ Update___

Food and Nutrition Service

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Comments:

Manager's Signature/Date:

Nursing

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Comments:

Nursing Signature/Date:

Physician Please Consider

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Name__________________________ Room__________ New____ Re-admit____ Update___

Food and Nutrition Service

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Comments:

Manager's Signature/Date:

Nursing

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Comments:

Nursing Signature/Date:

Physician Please Consider

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Medical Nutrition Therapy
Consultant Documentation Records

Date: ____________________

Rm	Name	PI/ PU	Wt ↓	New R	RA	Wt ↑	TF IV	Referral	PN	POC	MDS CAAs	Information

Key: Rm = room PI/PU = pressure injury/ulcer Wt ↓ = weight loss R = Resident RA = readmission Wt ↑ = weight gain
TF = tube feed IV = intravenous PN = progress note POC = plan of care MDS = minimum data set CAAs = care area assessment

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