

Nutrition Risk Screening Form

Name: _____ Pt #: _____ DOB: _____

Physician's Name: _____ Phone #: _____

Diagnosis: _____ Diet Order: _____

Height: _____ Weight: Current _____ 1 month ago _____ 6 months ago _____

Nutrition Risk Indicators: *(check/date all that apply)*

Indicator

Criteria

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight change from usual | <input type="checkbox"/> > 10 lb change in 3 months
<input type="checkbox"/> 5% weight change in 1 month | <input type="checkbox"/> BMI < 22 |
| <input type="checkbox"/> High Risk Diagnosis | <input type="checkbox"/> Hip Fracture / Replacement
<input type="checkbox"/> Pressure Ulcer, Wounds
<input type="checkbox"/> GI Disease
<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cancer
<input type="checkbox"/> CHF
<input type="checkbox"/> COPD
<input type="checkbox"/> Depression |
| <input type="checkbox"/> Complex Diet Order | <input type="checkbox"/> ≥ 3 dietary modifications
<input type="checkbox"/> Receiving medical nutritional supplement
<input type="checkbox"/> Transitioning from EN to oral, or PN to EN | <input type="checkbox"/> Tube feeding
<input type="checkbox"/> Parenteral nutrition support |
| <input type="checkbox"/> Physical Signs | <input type="checkbox"/> Poor skin turgor
<input type="checkbox"/> Dry mucous membranes
<input type="checkbox"/> Muscle wasting
<input type="checkbox"/> Weakness / tremors | <input type="checkbox"/> Edema
<input type="checkbox"/> Oral lesions
<input type="checkbox"/> Dull, dry and/or brittle hair |
| <input type="checkbox"/> Psycho-Social Factors | <input type="checkbox"/> No caregiver in the home
<input type="checkbox"/> No transportation | <input type="checkbox"/> Limited mobility (inability to prepare food)
<input type="checkbox"/> Limited funds to buy food |
| <input type="checkbox"/> Other: _____ | | |

Signed: _____ Date: _____

Nutrition Risk Determination/Intervention

- Low Risk (No indicators checked). Reassess in _____ days.
- Moderate Risk (One indicator checked).
- High Risk (Two or more indicators checked).

Interventions:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Initiate Interdisciplinary Care Plan for _____ | <input type="checkbox"/> Request RD Chart Consult |
| | <input type="checkbox"/> Request RD Home Referral |

Signed: _____ Date: _____