



0300008

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

NUTRITION RISK SCREENING FORM – SURGERY CLINIC (PILOT)

Please complete this page.

Height: _____ Current Weight: _____

Usual Body Weight: _____ (Your weight when you feel healthy, and your appetite is good.)

When is the last time you weighed your Usual Body Weight? Month/Year _____

- 1. Have you been having loose stools? Yes No
 - 1a. If YES, how long have you been having loose stools?
 - 1 month or less 6-12 months
 - 2-6 months longer than 1 year
- 2. Do you have: abdominal cramping bloating
 stools that float yellow stools oily stools
- 3. Do you have so much nausea or vomiting you cannot eat? Yes No
 - 3a. If YES, how frequently does your nausea/vomiting happen?
 - Multiple times a day A few times a week
 - Once per day A few times a month
- 4. Do you follow a low fat diet, or another special diet at home?
 (Examples: avoid butter/fried foods, low fat/fat free daily diet, diabetic diet, liquid/soft foods only)
 Yes No If YES, please describe _____
- 5. Do you take pancreatic or digestive enzymes? Yes No
 - 5a. If YES, when do you take them?
 - Before meals/snacks After meals/snacks During meals/snacks
- 6. Do you take nutritional supplements (such as Boost®, Ensure®, Carnation® Instant Breakfast)?
 Yes No If YES, please describe _____

Please complete if currently on Nutrition Support (Intravenous Nutrition or Tube Feedings)

- 1. How do you receive your nutrition?
 - Intravenous Tube to the stomach (PEG tube)
 - Tube to the intestine (J-tube) Tube to the intestine AND stomach (PEG-J)
- 2. Please describe your nutrition support. For instance: What is your tube feeding formula, if this applies? Rate? For how many hours? _____
- 3. Have you had any issues with your tube feedings or intravenous nutrition recently?
 Yes No If YES, please describe _____

Completed by: _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____

For Staff Use Only – Complete Documentation in Clinic Note in EMR

Dx/Planned Operation:

Date for Surgery:

History:

Pertinent Meds:

Actual Weight:

IBW/% IBW: _____

IBW: Translate height into weight;

Men: 106# for the first 5 ft of height PLUS 6# for each additional inch over 5 ft

Women: 100# for the first 5 feet of height PLUS 5# for each additional inch over 5 ft

% IBW: Current weight ÷ IBW

% UBW: _____

Current wt ÷ UBW

_____ % wt loss over _____

(100% - %UBW)

(Time period in weeks / months / years)

≤ 95% of **UBW x 1 month**

≤ 90% of **UBW x 6 month**

≤ 80% of **IBW**

Plan for Loose Stools:

Fecal Elastase

C. Diff Toxin

Random Fecal Fat

Suspected Abnormalities:

Albumin

Vitamin A

Vitamin E

Vitamin B12

Folate

25-Vitamin D

RBC

Ferritin

HbgA1C

Plan for ongoing weight loss:

Discussed with patient/family who expressed understanding of plan.

Completed by _____ Date _____ Time _____

Printed Name _____ PIC _____ Role _____