NUTRITIONAL EVALUATION/RE-EVALUATION

Admission Date:_____ Admitting Diagnosis:_____

Other Current Diagnoses:_____

Food Allergies:_____

Ideal Body Weight:_____ Usual Body Weight:_____ BMI:_____

DATE ▶	EVALUATION	NOTES/COMMENTS
Reason for Evaluation		
Current Diet/Texture		
Current Height		
Current Weight/Trend		
% Weight Change $\left(\frac{\text{usual wt - actual wt}}{\text{usual wt}}\right) \times 100$	1 mo._____ 3 mo._____ 6 mo._____	
Supplemental/Fortified Foods Needed	❍ No ❍ Yes (specify) _____	
Chew/Swallow Issues	❍ No ❍ Yes (specify) _____	
% of Food Intake/ Caloric Needs		
Fluid Intake/Fluid Consistency Requirements		
Ability to Feed Self	❍ No (specify) ❍ Yes _____	
Adaptive Devices Needed	❍ No ❍ Yes (specify) _____	
Skin Condition	❍ Intact ❍ Not Intact (specify) _____	
Chronic Vomiting/Diarrhea	❍ No ❍ Yes (specify) _____	
Edema Present	❍ No ❍ Yes (specify) _____	
Pertinent Labwork		
Pertinent Medications		
Resident Attitude Toward Diet		
Plan of Care Updated	❍ No ❍ Yes (date)_____	

_____ _____ _____ _____

Signature/Title Date Signature/Title Date

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed