SAVE PRINT

NUTRITION CARE PLAN

Name_____ **Date**_____ **Date of Birth**_____
Age_____ **Height**_____ **Admission Weight**_____ **Ideal body weight**_____
Allergies_____ **Diet**_____
Medication_____

SUBJECTIVE INFORMATION
Patient's Viewpoint of Problem_____

Previous Diet_____ Do you gain weight easily?_____
Have you loss weight recently?_____ If so, how many pounds?_____
Do you participate in any sport activities?_____ How often?_____
How many times a day do you eat?_____
Food likes:_____

Food dislikes:_____

Describe a typical meal that you would consume:_____

OBJECTIVE INFORMATION
Current weight_____ Current Height_____ BMI_____ %_____
Ideal Body weight_____ Goal weight_____ Usual weight_____
Significant Lab values_____
Family History_____
Basal Energy Expenditure_____

ASSESSMENT
Impression from data_____
Appropriateness of diet order_____

Patient's Understanding of diet and ability to follow diet:_____

PLAN:_____

Date

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CONSULT FROM: ☐ **Physician** ☐ **Nursing** ☐ **New PN/TF** ☐ **Other:**_____ Date:_____

ESTIMATED NEEDS: Calories:_____ **Protein:** _____**Fluids:**_____

`OBLEM/NUTRITION DIAGNOSIS

____ **Excessive/Inadequate Intake of:**_____**R/T:**_____
As evidenced by:_____

____ **Increased/Decreased Nutrient Needs R/T:**_____
As evidenced by:_____

____ **Inability to Meet Nutrient Needs R/T:**_____
As evidenced by:_____

____ **Knowledge Deficit R/T:**_____
As evidenced by:_____

____ **Potential/At Risk for:**_____**R/T:**_____
As evidenced by:_____

____ **Other:**_____**R/T:**_____
As evidenced by:_____

GOALS

_____**Maintain present weight of**_____**± 5lbs or 2.2kg**

_____**Meet estimated needs for:** ☐ Nutrients/Fluids

_____**Tolerate:** ☐ Diet ☐ Nutrition Support

_____**Comprehend;** ☐ Diet ☐ Nutrient needs

_____Other:_____

___ **p.o. intake ≥** _____**% of meals**

___**Maintain/Improve prealbumin ≥ 18 mg/dl**

___**Maintain comfort status**

INTERVENTION

_____**Order:**_____

_____**Monitor:** ☐ **Intake and Output** ☐ **p.o. Intake** ☐ **Supplement Intake** ☐ **Weight Status** ☐ **Pertinent Labs**

Tolerance of: ☐ **Diet** ☐ **Diet Consistency** ☐ **Nutrition Support** ☐ **Other:**_____

_____Provide Education on:_____

_____**Recommend:**_____

_____**Other:**_____

_____**Notify:** ☐ **Physician** ☐ **Nursing** **Via:** ☐ **Note** ☐ **Phone** ☐ **Discuss in Person**

_____**No Intervention at Present – Will Continue to Screen Daily per Standards**

EVALUATION

_____**Reassessment on:**_____

_____**Other:**_____

Medical Nutrition Therapist:_____**Date:**_____**Time:**_____

NUTRITION ASSESSMENT

DO NOT THIN FROM CHART

9215690

Addressograph

Updated: July/2018