MDS 3.0

Nutrition Screening Form

Initial ☐ Annual ☐ COC ☐

Ht _____ Wt ______ lbs ______ kg | Normal/UBW x 1 yr ________ lbs | Goal Wt range ______ to ______ | Wt Loss ☐ Gain ☐ of ______ lbs | Time: _____ day(s) _____ mo(s) _____ wk(s)

Amputation ☐ | Planned wt change regimen: ☐ No ☐ Yes, MD Prescribed ☐ Yes, not MD prescribed

Active Diagnosis & Special tx e.g. ☐ Hospice ☐ Dialysis ☐ Chemo/Radiation

Decub: ☐ Yes ☐ No If yes: Stage: ______ Location: ______________ Stage: ______ Location: ______________
Multiple: ☐ Yes ☐ No Stage: ______ Location: ______________ Stage: ______ Location: ______________

Diet RX: ______________________________
Nourishment RX ______________________________
Thickened Liquids ☐ Consistency N H P

Texture: ☐ Reg ☐ Puree ☐ Ground ☐ Chopped ☐Dysphagia Level ☐ 1 ☐ 2 ☐ 3
☐ with meals BID TID QID ☐ between meals BID TID ☐ HS
Med Pass ☐ ____________ cc/ml BID TID QID

DX that may impede ability to consume food:

☐ Cancer ☐ Septicemia ☐ Delirium ☐ Pneumonia ☐ Diabetes ☐ Anemia
☐ Chemo/Radiation ☐ Wound infection ☐ Diarrhea ☐ COPD/SOB ☐ Fever ☐ MRSA
☐ Alzheimer's ☐ Dementia ☐ Parkinson's ☐ Renal Disease ☐ Depression ☐ Malnutrition
☐ Dysphagia ☐ Confusion

Oral Status:

☐ Chewing
☐ Mouth Pain/Sores ☐ Poor Dentition
☐ Own Teeth ☐ Edentulous
☐ Dentures ☐ Complete
☐ Ill fitting dentures ☐ Partial
☐ Refuses to wear dentures ☐ Refuses Dental Consult

☐ Swallowing Intervention in place ☐ Yes ☐ No ☐ None
☐ Loss of Liquid/solids from mouth when eating or drinking
☐ Holding food in mouth/cheeks or residual foods in mouth after meals
☐ Coughing or choking during meals or when swallowing medications
☐ Complaints of difficulty or pain with swallowing

Factors that may impede self feeding

☐ Blind ☐ Shaky ☐ Comatose ☐ Tremors
☐ Extensive Contractures ☐ Extensive Paralysis ☐ Weakness ☐ Tires easily ☐ Recent CVA (active diagnosis)

Hydration Risk Factors:

☐ Poor PO intake ☐ Fever ☐ Anemia ☐ UTI ☐ Dilantin Rx
☐ Fluid Restriction ☐ Poor Fluid intake ☐ Tube Feeding ☐ Dysphagia/Thickened Liquids ☐ Diuretic
☐ Output exceeds intake ☐ Active Dehydration Dx ☐ ↑ S. Osmo ☐ Renal Disease ☐ Internal bleeding ☐ Vomiting
☐ Dependence on staff for fluid intake ☐ Impaction ☐ Constipation ☐ Diarrhea
☐ Hx of refusing fluids or lacking sensation of thirst

Number _____ (transfer to back page)

Factors that may impeded intake or cause wt loss:

☐ Active Depression Dx ☐ Taste Alteration
☐ Unable to state food preferences ☐ Too much food complaint ☐ Restrictive Therapeutic Diet ☐ Mental problems
☐ Leaves 25% or more of food uneaten at most meals ☐ Regular complaint of hunger ☐ Food Allergies ____________
☐ Restricts major food group(s) ______________________ ☐ Confusion ☐ Chronic Constipation
☐ Complains re: taste of many foods ☐ Chronic Pain Location __________ ☐ Behavioral problems
☐ Unable to understand the importance of eating ☐ Dependence on staff for food intake

Resident and/or family input into nutritional care including Advanced Directives:

Special Meal Time request	☐ Yes	☐ No	B	L	D

☐ Desires a snack between meals ☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not important at all
☐ Important, but can't do or no choice ☐ No response or non-responsive

Average PO intake % (Number of days ________)	B	L	D	Nx

Adaptive Equipment ☐ ☐ Total Assist ☐ Assist ☐ Independent ☐ Set up only ☐ Slow
☐ Refuses Feeding ☐ RNA Program ☐ Breakfast ☐ Lunch ☐ Dinner
☐ Uses food as a tool to get attention ☐ Unable to maintain posture

If readmission – note changes

Comments by DSS or RD

Signature: ______________________________ Date: __________ Time: __________

Signature: ______________________________ Date: __________ Time: __________

Resident Name ______________________________ Room ______ Age _____ Sex _____ Admit date: __________

Nutrition Risk Assessment Summary

Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not be feasible: (Circle ○) Terminal dx Refusal to Eat/refusal of other methods of Nx, Advanced disease e.g. Cardiac disease, Cancer, Pulmonary disease; Infections, Alcoholism, Rheumatoid arthritis, TB, Parkinsons, Debilitative Decline (Failure to Thrive), Malabsorption syndrome, Alzheimer's, Dementia, Renal disease, Drug abuse, Wound healing, Radiation or chemotherapy, Chronic Blood loss, Hyperthyroidism, GI surgery, Depression Prolonged N/V or diarrhea not relieved by treatment. Wt fluctuations- dialysis. **Malnutrition Dx or clinical indicators evident**

Medications with anorexia as major side effect: ABT Atrovent, Axid, Cipro, Coumadin, Dilantin, Duragesic, K-Rx Lanoxin (Digoxin), Lasix, Norvasc, Paxil, Pepcid, Premarin, Prilosec, Procardia, Propacet, Prozac, Synthroid, Risperdal, Vasotec, Zantac, Zoloft

HYDRATION Risk Factors: from the front page ______ number of risk factors. Implement plan outlined below if >3.

Other:

Lab Dates					
WBC					
Hgb/Hct					
Calc. TLC (Total Lymph. Count) [(WBC x 1,000) x % Lymph)]=					
Blood Sugar					
Albumin / Pre Albumin					
Na+					
K+					
Bun/Creat					
Calc GFR:					
Chol					
Calc. Serum Osmo 2(Na)+(Gluc/18)+(Bun/2.8)=					
BMI					

Edema BP

Kg Body Weight Decub:

Estimated Nutritional Needs

Kcals________________@________kcal/kg

Pro gms ______________@________gm/kg

Fluid ccs ______________@________cc/kg

Tube Feeding Provides

Rx

Cal____________________/__________cal/kg

Pro____________________/__________gm/kg

RDI's Adequate Yes No

Free Fluids ____________________________
Fluid Flush ____________________________

Total Fluid______________@________cc/kg

PLAN: Med Pass 2.0 _____ml ____x/d // Prostat ___ ml qd // House Nx with Meals // House Nx between Meals // Snacks between meals Hi Pro ice crm

Fortified Foods Benecal (7cal/cc) qd bid tid qid Protein Powder qd bid tid qid Multivit w/ min Vit C _______ mg ZnSo4 220 mg x 30d

Vit D3________________

Feed RNA feeding program Adjust dining or seating location Allow additional time to complete meals ST / OTR / Dental referral

Texture change to: Reg Chopped Ground (Mech Soft) Puree Additional fluids_______________ I & O x 3 days ______ml goal

MD eval need for Fe++ MD consider diet change/liberalization to: ________________________ FSS to review food preferences

__________________________ __________________________ __________________________ IV Hydration

Increase Fiber __________ Advanced Directives review by family, resident and SSD Hospice referral No grapefruit Limit Caffeine

Psych referral Transition to oral feeding from TF see plan: Pump Justification:

Change TWR to _________ to _________ lbs (Update care plan) Appetite Stim __________________ No extra veg or green tea (Coumadin) □

Labs: BMP, CMP, CBC , TSH, HGA1C Lipid Panel U/A Cal Count x 3 days Weekly Wts until stabilized Tube Feeding

Evaluate for pharmacologic interventions following failure of other interventions Other _________________ Proceed to CP

RD Signature ______________________________________ Date __________ Time ________ Resident___________________________________