FORM #2002

DIETITIAN CONSULTING SERVICE, LLC

TUBE FEEDING NUTRITION ASSESSMENT

Admission Date:_____

Date: _____

SUBJECTIVE:_____

_____

_____

_____

Does resident accept diet/texture (if applicable)? Yes/No Explain: _____

DATA COLLECTION			
DOB:	Age:	Gender:	Food Allergies/Intolerances:
Pertinent Diagnosis & PMH:			
Tube Feeding Order:			Tube Placement: NG / NJ / GT / JT
Diet/NPO:		Oral Intake:	
Justification for Pump or Formula:		Etiology for Tube Feeding:	
Height:	Weight:	UBW:	BMI:
Weight History/ Sig. Wt. Change (5% in 1 month, 7.5% in 3 months, 10% in 6 months):			
Mental Status:		Communication:	
Skin Integrity:		Bowel Abnormalities:	
Chewing/Swallowing Status:		Other:	

MEDICATIONS	

LABORATORY DATA					
DATE	**LAB**	**RESULT**	**DATE**	**LAB**	**RESULT**
	Albumin			Sodium	
	Pre-Albumin			Potassium	
	Hemoglobin			Phosphorus	
	Hematocrit			BUN	
	MCV			Creatinine	
	Calcium			Transferrin	
	Cholesterol			Osmolality	
	Triglyceride				
	Glucose/HbA1C				

Resident Name:_____Admit#:_____Physician:_____Room:_____

ASSESSMENT:

Estimated Nutritional Needs:

Calories:_____

Protein: _____

Fluid:_____

Tube Feeding Supplies:

Calories:_____

Protein: _____

Fluid: _____

Free Fluid From Formula:_____

Free Fluid From Flushes:_____

% RDI:_____

Comments: _____

NUTRITION DIAGNOSIS: ☐ No Nutrition Diagnosis at this time.

Problem:	Etiology:	Signs & Symptoms:
Problem:	Etiology:	Signs & Symptoms:

INTERVENTIONS:

(Nutrition Prescription, Food or Nutrient Delivery, Nutrition Education or Counseling, Coordination of Care, etc)

Goal(s):_____

MONITORING & EVALUATION: _____

RD Signature: _____ Date: _____

Resident Name:_____Admit#:_____Physician:_____Room:_____