(Name of Hospital)

ADMISSION ADULT
Nutrition Screening and Referral Tool

Name of Patient: _____Age: _____ Sex: _____
Address: _____Height: _____Weight: _____

Instructions: Mark each box appropriate to the patient. If the patient has at least ONE of the following conditions and/or histories, refer to the Registered Nutritionist-Dietitian for Medical Nutrition Therapy; otherwise, RESCREEN after three (3) days.

A. **CLINICAL CONDITION**	
☐ Admission to ICU	☐ Malabsorption (celiac sprue, ulcerative colitis, Crohn's disease, short bowel syndrome)
☐ Anorexia Nervosa/Bulimia Nervosa	☐ Multiple Trauma (closed head injury, penetrating trauma, multiple fractures)
☐ Cachexia (temporal wasting, muscle wasting, cancer, cardiac)	☐ Non-healing wounds, Pressure Injury
☐ Cerebrovascular accident	☐ On tube feeding/parenteral nutrition
☐ Coma	☐ Renal Disease (acute, chronic, undergoing dialysis)
☐ Diabetes Mellitus/Gestational Diabetes Mellitus	☐ Sepsis
☐ Gastrointestinal disease or complication	☐ Serum albumin <3.5 gm/L
☐ Liver disease	
B. INTAKE/WEIGHT HISTORY	
☐ Unintentional weight loss in the past 3 months	☐ Pregnant patient is aged $\leq$ 18 years old or $\geq$ 35 years old
☐ Reduced dietary intake in the past week	☐ Pregnancy with Hyperemesis gravidarum/ Pregnancy-Induced Hypertension
☐ BMI below 18.5 and above 30 *(to be computed by the RND)*	☐ Multiple Pregnancy
☐ Others: _____	☐ Lactating Mother

Reference: *Kovacevich, Debra S.; Boney, Anthony R.; Braunschweig, Carol L.; Perez, Anne; Stevens, Mary (1997). "Nutrition Risk Classification: A Reproducible and Valid Tool for Nurses." Nutrition in Clinical Practice 12(1): 20-25.*

Accomplished by:

_____   _____
Signature over **PRINTED NAME** of the Nurse   Date/Time

(Name of Hospital)
REFERRAL FOR MEDICAL NUTRITION THERAPY

Diagnosis: _____

Diet Prescription: _____

☐ *Per Orem*	☐ *Tube Feeding*	☐ *NPO/TPN*

Referred by:

_____   _____
Signature over **PRINTED NAME** of the Physician   Date/Time