
 <b>OSPITAL NG PARANAQUE</b> 		Document Code: <b>OSPAR-ADS-NDS-029</b>
<b>ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX</b>		Implementation Date: 2019
		Page No. <b>1 of 12</b>
		Section / Department: <b>NUTRITION AND DIETETICS SERVICE</b>
<b>Policy Title:</b>  <b>NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES</b>	<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Paranaque
	<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Paranaque	

## **CLASSIFICATION: COMPREHENSIVE**

### **OBJECTIVES:**

This policy shall provide individual counseling and develop meal plans that can change lives and help patients who are dealing with diseases, such as diabetes, cardiovascular disease or obesity-related cancers/ non-communicable diseases.



### **COVERAGE:**

This policy covers this section and the concerned department/section.

### **POLICY:**



- Clinical Nutrition Services are provided to the following:
  - Nutritionally-at-risk patients
  - Patients referred to Specialized Center/Section
  - Patients on Enteral and Parenteral feeding
  - Outpatients referred to the NDS
- The Clinical Nutrition Services are the following:
  - Nutrition Screening and Assessment
  - All admitted patients to the hospital shall undergo a nutrition screening process within 24-48 hours upon admission.
  - The medical intern and/or resident shall completely accomplish the Nutrition Screening and Referral Tool of the hospital. Such record must be available in the patient's chart for review and evaluation.
  - A Nutritional Risk Score of Two (2) and above should be referred to the Nutrition and Dietetics Service for further assessment.
  - A Nutritional Risk Score of One (1) may also be referred for assessment depending on the order of the doctor, however, if patient is in critical care unit (e.g., ICU, CCU, NEURO-ICU, etc.), one must be referred for further assessment.

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.

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<b>ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX</b>		Implementation Date: 2019
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<b>Policy Title:</b>  <b>NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES</b>	<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Paranaque
		<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Paranaque



- A Nutritional Risk Score of Zero (0) means that there is no impending nutritional risk. Re-screening should be done after a week or seven (7) days to assess the current status.
  - Patients identified as nutritionally-at-risk through the hospital's nutrition screening process shall undergo a nutrition assessment.
  - Nutrition assessment tools include:
    - Nutrition Screening and Referral Tool(Adult/Pediatric)
    - Nutrition Screening and Assessment Form (Adult/Pediatric)
    - Medical Nutrition Therapy Form
    - Subjective Global Assessment Form
    - Food Record Form
    - Other pertinent tools
  - The assigned Clinical Dietitian shall conduct ward rounds for nutrition assessment based on the result of the nutrition screening.
  - The assigned Clinical Dietitian shall propose a nutrition care plan/diet recommendation for the approval of the Attending Physician based on the outcome of nutrition assessment.
3. Nutrient Intake Monitoring (Calorie Counting)
- The Food Record Form will be used for such service.
4. Nutrition Counseling and Intervention
- The Clinical Dietitian shall recommend the calories, macronutrients and micronutrients, additional supplementation, monitoring of implementation and other needed intervention for patient care.
  - The Clinical Dietitian may follow up the physician's approval for Nutrition Care Plan/ Diet Recommendation provided for Nutrition Intervention or may follow physician's recommendation for Nutrition Counseling.
  - Nutrition Counseling for inpatients and outpatients may be conducted at the patient's room, Dietary Department, or at the Special Areas/Center (Diabetes and Endocrine Center/Cardiac Rehabilitation Center/Hemodialysis Unit, etc.) of the hospital.

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<b>Policy Title:</b>  <b>NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES</b>	<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Paranaque
	<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Paranaque	

5. Clinical Nutrition Services for inpatients and outpatients are facilitated by the Dietary Prescription Form of the department or through the established hospital's information system for the department.
  - Dietary Prescription Form should include the following data:
    - Admission #
    - Patient's #
    - Patient Name
    - Room
    - Height
    - Weight
    - Birthdate
    - Age
    - Diagnosis
    - Doctor's order/dietary prescription
    - Other procedure/biochemical results/ service request for proper endorsement/referral
    - Attending Physician's name
    - Full name of Nurse's on Duty
6. The Clinical Nutrition Services are made available to patients from Monday to Saturday during 8:00am to 4:00pm only.
  - Nutrition counseling requests for possible discharge in-patients should be made at least one (1) day before the actual discharge day of the patient.
  - The nutrition counseling service may be done on the day of the actual discharge for a better memory retention; however, it may also be upon the discretion of the physician or the patient.
  - Patients referred for such services on a Sunday and Holiday will be scheduled on the following working day.
    - In the event that an inpatient is referred for Nutrition Counseling to the Dietary Department on a Sunday or Holiday and is on 'May-Go-Home' status, instruction will be done at the Dietary Department to the available relative of the patient.

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.

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<b>ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX</b>		Implementation Date: 2019
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<b>Policy Title:</b>  <b>NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES</b>	<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Paranaque
		<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Paranaque

- In an Emergency cases, if the patients referred on Sunday or Holiday that required immediate Clinical Nutrition Services, the Nutrition and Dietetics Service will only provide Nutrition counseling from 8:00-4:00pm only.
- For all patients in home care services, the assigned Clinical Dietitian who managed and handled their patient cases shall follow-up thru phone text messages (SMS) for continuous monitoring of patients' nutritional status (if required).
- In case the Clinical Dietitian cannot report to work due to a valid reason (sickness/an emergency and weather disturbance), s/he should inform the Chief Dietitian in advance to look for a reliever or the Clinical Dietitian on duty will extend his/her duty to cover his/her co-worker duty.
- For Patients under Diabetes Endocrine Center, Hemodialysis Unit etc., if the Center/Section has separate acknowledgment form/logbook, the Nutrition and Dietetics Service shall copy the list of patients only. There is no need for another acknowledgment form to be issued by the Department.



7. Exclusion criteria/s:

- Patient/ Doctor's refusal
- Preference for a Private Dietitian
- Natural and Unavoidable Circumstance

**APPENDIX**

- H:** Nutrition Screening and Referral Tool
- I:** Nutrition Screening and Assessment Form
- J:** Medical Nutrition Therapy Form
- K:** Subjective Global Assessment Form
- L:** Food Record Form
- M:** Dietary Prescription Form

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.

 <b>OSPITAL NG PARANAQUE</b> 		Document Code: <b>OSPAR-ADS-NDS-029</b>
		Implementation Date: 2019
<b>ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX</b>		Page No. <b>5 of 12</b>
<b>Policy Title:</b> <b>NUTRITION AND DIETETICS SERVICE</b> <b>POLICY ON CLINICAL NUTRITION SERVICES</b>		Section / Department: <b>NUTRITION AND DIETETICS SERVICE</b>
<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Parañaque	<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Parañaque

## APPENDIX H: NUTRITION SCREENING AND REFERRAL TOOL (ADULT)

### OSPITAL NG PARAÑAQUE 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 the Medical Nutrition Therapy; otherwise, RESCREEN after three (3) days.

<b>A. <u>CLINICAL CONDITION</u></b> <input type="checkbox"/> Admission to ICU <input type="checkbox"/> Anorexia Nervosa/ Bulimia Nervosa <input type="checkbox"/> Cachexia (temporal wasting, muscle wasting, cancer, cardiac) <input type="checkbox"/> Cerebrovascular accident <input type="checkbox"/> Coma <input type="checkbox"/> Diabetes Mellitus/Gestational Diabetes Mellitus <input type="checkbox"/> Gastrointestinal disease or complication <input type="checkbox"/> Liver disease	<input type="checkbox"/> Malabsorption (celiac sprue, ulcerative colitis, Crohn's disease, short bowel syndrome) <input type="checkbox"/> Multiple trauma (closed heads injury, penetrating trauma, multiple fractures) <input type="checkbox"/> Non-healing wounds, Pressure injury <input type="checkbox"/> On tube feeding/ parenteral nutrition <input type="checkbox"/> Renal disease (acute, chronic, undergoing dialysis) <input type="checkbox"/> Sepsis <input type="checkbox"/> Serum albumin <3.5 gm/L
<b>B. <u>INTAKE/ WEIGHT HISTORY</u></b> <input type="checkbox"/> Unintentional Weight loss in the past 3 months <input type="checkbox"/> Reduced dietary intake in the past week <input type="checkbox"/> BMI below 18.5 and above 30 ( <i>to be computed by the RND</i> )	<input type="checkbox"/> Pregnant patient is aged <= 18 years old or >= 35 year old <input type="checkbox"/> Pregnancy with Hyperemesis gravidarum/ Pregnancy-Induced Hypertension <input type="checkbox"/> Multiple Pregnancy <input type="checkbox"/> 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.

<b><u>Accomplished by:</u></b>	
_____ Signature over <b>PRINTED NAME</b> of the Nurse	_____ Date/Time



### OSPITAL NG PARAÑAQUE **REFERRAL FOR MEDICAL NUTRITION THERAPY**

Diagnosis: \_\_\_\_\_  
 Diet Prescription: \_\_\_\_\_

<input type="checkbox"/> Per Orem	<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> NPO/ TPN
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<b><u>Referred by:</u></b>	
_____ Signature over <b>PRINTED NAME</b> of the Physician	_____ Date/Time

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.

 <b>OSPITAL NG PARANAQUE</b> 		Document Code: <b>OSPAR-ADS-NDS-029</b>
		Implementation Date: 2019
<b>ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX</b>		Page No. <b>6 of 12</b>
<b>Policy Title:</b> <b>NUTRITION AND DIETETICS SERVICE</b> <b>POLICY ON CLINICAL NUTRITION SERVICES</b>		Section / Department: <b>NUTRITION AND DIETETICS SERVICE</b>
<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Parañaque	<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Parañaque

## APPENDIX H: NUTRITION SCREENING AND REFERRAL TOOL (PEDIATRIC)

### OSPITAL NG PARAÑAQUE ADMISSION PEDIATRIC 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 the Medical Nutrition Therapy; otherwise, RESCREEN after three (3) days.

<b>A. CLINICAL CONDITION</b> <input type="checkbox"/> Admission to ICU <input type="checkbox"/> Anorexia Nervosa/ Bulimia Nervosa <input type="checkbox"/> Cachexia (temporal wasting, muscle wasting, cancer, cardiac) <input type="checkbox"/> Cerebrovascular accident <input type="checkbox"/> Coma <input type="checkbox"/> Congenital anomalies (e.g. Down's Syndrome, Craniofacial Anomalies, Spina bifida, Hydrocephalus, Chiari Malformation) <input type="checkbox"/> Diabetes Mellitus/Gestational Diabetes Mellitus <input type="checkbox"/> Gastrointestinal disease or complication/ impending GI surgery (e.g. Pancreatitis, Inflammatory Bowel Disease, GERD, Malabsorption Conditions, Crohn's Disease) <input type="checkbox"/> Inborn errors of metabolism	<input type="checkbox"/> Inflammatory Disease (e.g. Sepsis, Encephalitis, Meningitis, Kawasaki Disease, Enterocolitis, Community-acquired pneumonia, Upper/ Lower Respiratory Tract Infection) <input type="checkbox"/> Liver disease <input type="checkbox"/> Malabsorption (celiac sprue, ulcerative colitis, Crohn's disease, short bowel syndrome) <input type="checkbox"/> Multiple trauma (closed heads injury, penetrating trauma, multiple fractures) <input type="checkbox"/> Neurologically-challenged (e.g. ADHD, Cerebral palsy, seizure disorders, Infantile spasms) <input type="checkbox"/> On tube feeding/ parenteral nutrition <input type="checkbox"/> Renal disease (acute, chronic, undergoing dialysis) <input type="checkbox"/> Sepsis <input type="checkbox"/> Serum albumin <3.5 gm/L
<b>B. INTAKE/ WEIGHT HISTORY</b> <input type="checkbox"/> Unintentional Weight loss in the past 3 months <input type="checkbox"/> Patient on breastmilk feeding <input type="checkbox"/> Reduced dietary intake in the past week <input type="checkbox"/> Reduction of dietary intake in the past week/s and/or during the hospital stay <input type="checkbox"/> For patients ages >5 years old to <18 years old, 364 days: <input type="checkbox"/> BMI z-score above +2 and below -2 (c/o RND)	<input type="checkbox"/> For patients ages >2-5 years old: <input type="checkbox"/> Weight for Height z-scores above +2 and below -2 (c/o RND) <input type="checkbox"/> For patients ages 1 month – 2 years old: <input type="checkbox"/> Weight for Length z-scores above +2 and below -2 (c/o RND)

**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 <b>PRINTED NAME</b> of the Nurse	_____ Date/Time
--	--------------------

### OSPITAL NG PARAÑAQUE REFERRAL FOR MEDICAL NUTRITION THERAPY

Diagnosis: \_\_\_\_\_

Diet Prescription: \_\_\_\_\_

<input type="checkbox"/> Per Orem	<input type="checkbox"/> Tube Feeding	<input type="checkbox"/> NPO/ TPN
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**Referred by:**

_____ Signature over <b>PRINTED NAME</b> of the Physician	_____ Date/Time
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**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.



# OSPITAL NG PARANAQUE



Document Code: **OSPAR-ADS-NDS-029**

Implementation Date: 2019

## ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX

Page No. **7 of 12**

**Policy Title:**

### NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES

Section / Department:

**NUTRITION AND DIETETICS SERVICE**

**Prepared By:**

**Kara Angelica L. Benavente, RND, MPA**  
Chief Dietitian, Nutrition and Dietetics Service

**Reviewed By:**

**Redentor P. Alquiros, MD**  
Chief of Clinics

**Darius J. Sebastian, MD, MPH, PHSAE**  
Hospital Administrator, Ospital ng Parañaque

**Approved by:**

**Jefferson R. Pagsisihan, MD, MHM**  
Hospital Director, Ospital ng Parañaque

## APPENDIX I: NUTRITION SCREENING AND ASSESSMENT FORM (ADULT) CLINICAL NUTRITION SERVICE NUTRITION SCREENING AND ASSESSMENT FORM

Name: \_\_\_\_\_ Room No: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Hospital No: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

SCREENING CRITERIA FOR POTENTIAL NUTRITIONAL RISK (check appropriate box)		
<input type="checkbox"/> Food intake	<input type="checkbox"/> Burns	<input type="checkbox"/> Chronic pain
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Old age
<input type="checkbox"/> Physical signs of malnutrition	<input type="checkbox"/> Multi trauma	<input type="checkbox"/> Depression
<input type="checkbox"/> Radiation therapy	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Dentures
<input type="checkbox"/> Expected hospital stay $\geq$ 2 weeks	<input type="checkbox"/> Fistulae	<input type="checkbox"/> Frequent diarrhea/ vomiting
<input type="checkbox"/> Malabsorption	<input type="checkbox"/> Cancer	<input type="checkbox"/> Anorexia
	<input type="checkbox"/> On tube feeding	
SUBJECTIVE DATA		
Food Intake: _____ No change _____ Mostly Liquids _____ Sub-Optimal _____ Starvation _____ Poor intake prior to Admission Functional Capacity: _____ In bed _____ Ambulatory _____ Needs Assistance Chewing/ Swallowing Difficulties: _____ Constipation: _____ Diarrhea: _____ Food Allergies: _____ Present Diet Rx: _____		Height: _____ (cm)      Weight: _____ (kg) Usual Weight: _____ kg      BMI: _____ Weight Change: _____% over _____ months/weeks % IBW: _____ Significant Labs: Albumin _____      Total Lym Count _____ HCT _____      HGB _____ Others: _____ _____ Medications: _____ _____ _____
SCORING OF NUTRITIONAL RISK RELATED RISK FACTORS		
<input type="checkbox"/> Screening criteria for potential nutritional risk one check or more (1-2 points) <input type="checkbox"/> $<85\%$ or $>130\%$ Ideal Body Weight (1 point) <input type="checkbox"/> Unintentional weight loss _____% over _____ months/weeks (2 points)		<input type="checkbox"/> Mechanical/ Digestive problem (1 point) <input type="checkbox"/> Depressed Albumin (1 point) <input type="checkbox"/> Significant Lab result (1 point) <input type="checkbox"/> Other: _____ Total Points: _____
A Nutrition Risk Factor with the following total score indicates:		
<input type="checkbox"/> 1- Low Risk <input type="checkbox"/> 2-3 Moderate <input type="checkbox"/> $>3$ High Risk		
Nutritional Status: <input type="checkbox"/> Normal <input type="checkbox"/> Moderate Malnutrition <input type="checkbox"/> Severe Malnutrition		
DIETITIAN'S RECOMMENDATION		
<input type="checkbox"/> Shift diet to _____ <input type="checkbox"/> Monitor Caloric Intake <input type="checkbox"/> Nutrition Education <input type="checkbox"/> Total Caloric Reqt. _____ <input type="checkbox"/> Request for Laboratory Date      Total Protein Reqt. _____ Other: _____ _____ _____		

Name of Dietitian / Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
License Number: \_\_\_\_\_

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.





# OSPITAL NG PARANAQUE



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## ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX

Page No. **8 of 12**

**Policy Title:**

### NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES

Section / Department:

**NUTRITION AND DIETETICS SERVICE**

**Prepared By:**

**Kara Angelica L. Benavente, RND, MPA**  
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**Reviewed By:**

**Redentor P. Alquiros, MD**  
Chief of Clinics

**Darius J. Sebastian, MD, MPH, PHSAE**  
Hospital Administrator, Ospital ng Paranaque

**Approved by:**

**Jefferson R. Pagsisihan, MD, MHM**  
Hospital Director, Ospital ng Paranaque

## PEDIATRIC NUTRITION NUTRITION SCREENING AND ASSESSMENT FORM

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Room No: \_\_\_\_\_ Hospital No: \_\_\_\_\_

Attending Physician: \_\_\_\_\_ Date Admitted: \_\_\_\_\_

Medical Problems: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### SCREENING CRITERIA FOR POTENTIAL NUTRITIONAL RISK (Full Assessment if one checked)

- |  |  |
|--|--|
| <input type="checkbox"/> Disproportionate weight for height          | <input type="checkbox"/> With dental problems                                |
| <input type="checkbox"/> Many food dislikes (if known)               | <input type="checkbox"/> Has feeding or eating problems- difficulty chewing, |
| <input type="checkbox"/> On a special diet (DM diet etc.)            | difficulty sucking, chokes on solid etc.                                     |
| <input type="checkbox"/> Child is allergic or intolerant to any food | <input type="checkbox"/> Others: please specify feeding problem _____        |
| <input type="checkbox"/> Picky eater                                 |  |
| <input type="checkbox"/> Child is on tube feeding                    |  |

### COMPREHENSIVE ASSESSMENT

#### SUBJECTIVE DATA

Food Intake: \_\_\_\_\_ No change \_\_\_\_\_ Sub-Optimal  
 \_\_\_\_\_ Mostly Liquid \_\_\_\_\_ Starvation  
 Functional Capacity: \_\_\_\_\_ In bed  
 \_\_\_\_\_ Ambulatory  
 \_\_\_\_\_ Needs Assistance  
 Constipation: \_\_\_\_\_ Diarrhea: \_\_\_\_\_  
 Food Allergies: \_\_\_\_\_  
 Food Intolerance: \_\_\_\_\_  
 Cultural, Social Concerns: \_\_\_\_\_

#### OBJECTIVE DATA

Height: \_\_\_\_\_ inches or \_\_\_\_\_ cm.  
 Weight: \_\_\_\_\_ lbs. or \_\_\_\_\_ kg.  
 Head circumference: \_\_\_\_\_ inches or \_\_\_\_\_ cm  
 Weight / Age percentile: \_\_\_\_\_ BMI: \_\_\_\_\_  
 Height / Age percentile: \_\_\_\_\_  
 Weight / Height percentile: \_\_\_\_\_  
 Lab Data: \_\_\_\_\_  
 Medications: \_\_\_\_\_

### SCORING OF NUTRITIONAL RISK RELATED RISK FACTORS

- |   |  |
|---|--|
| <input type="checkbox"/> Screening criteria for potential nutritional risk one check or more (1-2 points) | <input type="checkbox"/> Mechanical/ Digestive problem (1 point) |
| <input type="checkbox"/> Weight below 5% or above 3 SD % (1 point)  | <input type="checkbox"/> Depressed Albumin (1 point)             |
| <input type="checkbox"/> Unintentional weight loss _____% over _____ months/weeks (2 points)              | <input type="checkbox"/> Significant Lab result (1 point)        |
|   | <input type="checkbox"/> Other: _____                            |
|   | Total Points: _____  |

### A Nutrition Risk Factor with the following total score indicates:

☐ 1- Low Risk ☐ 2-3 Moderate ☐ > 3 High Risk

**Nutritional Status:** ☐ Normal ☐ Moderate Malnutrition ☐ Severe Malnutrition

### DIETITIAN'S RECOMMENDATION

- |  |   |
|--|---|
| <input type="checkbox"/> Shift diet to _____         | <input type="checkbox"/> Monitor Caloric Intake   |
| <input type="checkbox"/> Nutrition Education         | <input type="checkbox"/> Total Caloric Req. _____ |
| <input type="checkbox"/> Request for Laboratory Date | Total Protein Req. _____                          |
| Other: _____   |   |

Name of Dietitian / Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License Number: \_\_\_\_\_

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.





# OSPITAL NG PARANAQUE



Document Code: **OSPAR-ADS-NDS-029**

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## ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX

Page No. **9 of 12**

**Policy Title:**

### NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES

Section / Department:

**NUTRITION AND DIETETICS SERVICE**

**Prepared By:**

**Kara Angelica L. Benavente, RND, MPA**  
Chief Dietitian, Nutrition and Dietetics Service

**Reviewed By:**

**Redentor P. Alquiros, MD**  
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**Darius J. Sebastian, MD, MPH, PHSAE**  
Hospital Administrator, Ospital ng Paranaque

**Approved by:**

**Jefferson R. Pagsisihan, MD, MHM**  
Hospital Director, Ospital ng Paranaque

## APPENDIX J: MEDICAL NUTRITION THERAPY FORM

### OSPITAL NG PARANAQUE NUTRITION AND DIETETICS SERVICE MEDICAL NUTRITION THERAPY FORM (NUTRITION CARE PLAN)

Name (Last, First, MI): \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Hospital No: \_\_\_\_\_  
Name of attending Physician: \_\_\_\_\_ Date of Admission: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Religion: \_\_\_\_\_

NUTRITION ASSESSMENT	
Present Diet of Patient: _____	Height: _____ (cm) Weight: _____ (kg)
_____ No change	Usual Weight: _____ kg BMI: _____
_____ Mostly Liquids	Weight Change: _____ % over _____ months/weeks
<b>Food Intake:</b> _____ Sub-Optimal	% IBW: _____
_____ Starvation	<b>Biochemical Data</b>
_____ Poor intake prior to admission	Albumin: _____ Hematocrit: _____
<b>Functional Capacity:</b> _____ Bedridden	BUN: _____ Hemoglobin: _____
_____ Ambulatory	Calcium: _____ LDL: _____
_____ Needs assistance	Cholesterol: _____ Phosphate: _____
Chewing/ Swallowing Difficulties: _____	Creatinine: _____ Potassium: _____
Constipation: _____ Diarrhea: _____	Glucose: _____ Sodium: _____
Food Allergies: _____	HbA1C: _____ Triglycerides: _____
Food Intolerance: _____	HDL: _____ URR: _____
<b>Medications:</b> _____	Others: _____
	BP: _____ Acid Base Gas (ABG): _____

NUTRITIONAL STATUS
<input type="checkbox"/> Normal <input type="checkbox"/> Moderate Malnutrition <input type="checkbox"/> Severe Malnutrition

NUTRITION DIAGNOSIS (Problems, Etiology, Signs, and Symptoms)
_____ related to _____ as evidenced by _____.

NUTRITION INTERVENTION
Total Energy Requirement: _____
Carbohydrate grams/day: _____ Protein grams/day: _____ Fat grams/day: _____
Others (e.g. micronutrients): _____
<input type="checkbox"/> Shift diet to: ( ) Per Orem ( ) Tube Feeding ( ) TPN
<input type="checkbox"/> Nutrition Education on _____
<input type="checkbox"/> Request for Laboratory Results: _____ Others: _____

NUTRITION MONITORING AND EVALUATION
<input type="checkbox"/> Adequacy of Intake: ( ) Calories ( ) Protein ( ) Fluid <input type="checkbox"/> Compliance to Diet
<input type="checkbox"/> GI Tolerance <input type="checkbox"/> Weight Changes

<b><u>Recommended by: Conforme (Attending Physician):</u></b>
_____ (PRINTED NAME & SIGNATURE OF RND)
_____ (PRINTED NAME & SIGNATURE OF MD)

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.



# OSPITAL NG PARANAQUE



Document Code: **OSPAR-ADS-NDS-029**

Implementation Date: 2019

## ANCILLARY DIVISION HOSPITAL POLICIES AND PROCEDURES MANUAL APPROVAL MATRIX

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### Policy Title:

### NUTRITION AND DIETETICS SERVICE POLICY ON CLINICAL NUTRITION SERVICES

Section / Department:

**NUTRITION AND DIETETICS SERVICE**

### Prepared By:

**Kara Angelica L. Benavente, RND, MPA**  
Chief Dietitian, Nutrition and Dietetics Service

### Reviewed By:

**Redentor P. Alquiros, MD**  
Chief of Clinics

**Darius J. Sebastian, MD, MPH, PHSAE**  
Hospital Administrator, Ospital ng Paranaque

### Approved by:

**Jefferson R. Pagsisihan, MD, MHM**  
Hospital Director, Ospital ng Paranaque

## APPENDIX K: SUBJECTIVE GLOBAL ASSESSMENT FORM

### NUTRITIONAL ASSESSMENT SUBJECTIVE GLOBAL ASSESSMENT OF NUTRITIONAL STATUS

Name of Patient: \_\_\_\_\_

Ward/Room No.: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

#### A. History

##### 1. Weight Change

Overall loss in past 6 months: \_\_\_\_\_ kg. % Loss \_\_\_\_\_  
Change in past 2 weeks: \_\_\_\_\_ Increase \_\_\_\_\_ No change \_\_\_\_\_ Decrease

##### 2. Dietary intake change relative to Normal

No change \_\_\_\_\_  
Change \_\_\_\_\_ Duration \_\_\_\_\_ Weeks \_\_\_\_\_  
Type: Sub Optimal solid diet \_\_\_\_\_ Full Liquid diet \_\_\_\_\_  
Hypocaloric liquid \_\_\_\_\_ Starvation \_\_\_\_\_

##### 3. Gastrointestinal symptoms (persisted for 2 weeks)

None \_\_\_\_\_ Nausea \_\_\_\_\_ Vomiting \_\_\_\_\_ Diarrhea \_\_\_\_\_ Anorexia \_\_\_\_\_

##### 4. Functional Capacity

No dysfunction \_\_\_\_\_  
Dysfunction: Duration \_\_\_\_\_ Weeks \_\_\_\_\_  
Type: Working sub-optimally \_\_\_\_\_ Ambulatory \_\_\_\_\_ Bedridden \_\_\_\_\_

##### 5. Disease and its relationship to nutritional requirements

Primary Diagnosis: \_\_\_\_\_  
Metabolic Demand Stress: No \_\_\_\_\_ Low \_\_\_\_\_ Moderate \_\_\_\_\_ High \_\_\_\_\_



#### B. Physical (for each specify: 0=normal, 1+=mild, 2+=moderate, 3+=severe)

Loss of subcutaneous fat (triceps, chest) \_\_\_\_\_  
Muscle wasting (Quadriceps, deltoids) \_\_\_\_\_  
Ankle edema \_\_\_\_\_ Sacral edema \_\_\_\_\_ Ascites \_\_\_\_\_

#### C. Subjective Global Assessment Rating

Well-nourished A. \_\_\_\_\_  
Suspected or moderately malnourished B. \_\_\_\_\_  
Severely malnourished C. \_\_\_\_\_

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<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Parañaque	<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Parañaque

## APPENDIX L: FOOD RECORD FORM

### OSPITAL NG PARAÑAQUE NUTRITION AND DIETETICS SERVICE



#### 24 HOUR FOOD RECORD FORM

Name of Patient: \_\_\_\_\_  
 Ward/Room No.: \_\_\_\_\_  
 Attending Physician: \_\_\_\_\_  
 Diet: \_\_\_\_\_

NOTE: Please complete one day (24 hrs) intake before giving to Nutrition and Dietetics Service.  
 IF PATIENT DID NOT EAT NOR DRINK, WRITE "NOTHING". Include sugar used.

DATE AND TIME	SPECIFIC FOOD ITEMS	QUANTITY/AMOUNT	KILOCALORIES (to be completed by RND)

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<b>Prepared By:</b>  <b>Kara Angelica L. Benavente, RND, MPA</b> Chief Dietitian, Nutrition and Dietetics Service	<b>Reviewed By:</b>  <b>Redentor P. Alquiros, MD</b> Chief of Clinics  <b>Darius J. Sebastian, MD, MPH, PHSAE</b> Hospital Administrator, Ospital ng Parañaque	<b>Approved by:</b>  <b>Jefferson R. Pagsisihan, MD, MHM</b> Hospital Director, Ospital ng Parañaque

### APPENDIX M: DIETARY PRESCRIPTION FORM

Kara Angelica Libera-Benavente, RND, MPA  
 Chief Dietitian  
 Ospital Ng Parañaque  
 Tel no. 8254902 to 04 local 352  
[karabenavente@yahoo.com](mailto:karabenavente@yahoo.com)

Patient's Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date: \_\_\_\_\_  
 B-day: \_\_\_\_\_  
 Daily Caloric Requirement; \_\_\_\_\_ Kcal  
 Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_ IBW: \_\_\_\_\_  
 BMI: \_\_\_\_\_ Nutritional Status: \_\_\_\_\_  
 Dietary Prescription Breakdown:  
       \_\_\_\_\_ CHO  
       \_\_\_\_\_ Protein  
       \_\_\_\_\_ Fats  
 Nutritional Suggestion:  
 \_\_\_\_\_ Vegetables    \_\_\_\_\_ Rice    \_\_\_\_\_ Meat    \_\_\_\_\_ Beverage  
 \_\_\_\_\_ Fruits        \_\_\_\_\_ Bread    \_\_\_\_\_ Oils    \_\_\_\_\_ Sweetener  
 Nutritional Supplements: \_\_\_\_\_  
 Nutrition Notes: \_\_\_\_\_

\_\_\_\_\_, RND  
 License No: \_\_\_\_\_  
 PTR No: \_\_\_\_\_

**SCHEDULE FOR POLICY REVIEW:** This policy shall be reviewed when deemed necessary.