Nutritional Assessment

Resident: _____ Room: _____ Admission Date: _____

Assessment Type: _____ Diagnosis: _____ Age: _____

Medical Hx: _____

_____

Medications Affecting Nutritional Status: _____

_____

Diet: _____ Intake: _____ Food Allergies/Intolerances: _____

Adaptive Dining Devices: _____ Eating Capability: _____

Swallowing Issues: _____ Chewing Issues: _____ Dentures: _____

Dining Location: _____ Ambulation: _____ Urinary Incontinence: _____

Kcal Needs: _____ Kcal/kg: _____

Protein Needs: _____ g/kg _____

Fluid Needs: _____ mL/kg _____

Height: _____ Weight: _____ Adjusted Weight: _____ Ideal Weight Range: _____

Weight x1 mo. _____ Weight x3 mo. _____ Weight x6 mo. _____ Weight x1 yr. _____

Plan/Recommendations: _____

_____

Signature: _____ Date: _____