

# OAK HILLS LIVING CENTER NUTRITIONAL ASSESSMENT QUARTERLY REVIEW

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ CASE # \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ ADMIT DATE \_\_\_\_\_ ROOM # \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

HEIGHT \_\_\_\_\_ ADMIT WEIGHT \_\_\_\_\_

IBW \_\_\_\_\_ USUAL WEIGHT \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

DIET ORDER \_\_\_\_\_

DIET RATIONALE \_\_\_\_\_

ACCEPTS DIET    Y \_\_\_\_\_ N \_\_\_\_\_                      EATING LOCATION \_\_\_\_\_

NOURISHMENTS:

BREAKFAST \_\_\_\_\_

10:00 AM \_\_\_\_\_

NOON MEAL \_\_\_\_\_

2:00 PM \_\_\_\_\_

SUPPER \_\_\_\_\_

HS \_\_\_\_\_

QUARTER	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>
DATE				
SIGNATURE				

QUARTER	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>
<b>NUTRITIONAL NEEDS / BMI</b>				
KCAL NEEDS				
PROTEIN NEEDS				
FLUID NEEDS				
<b>EATING ABILITY</b>				
INDEPENDENT				
SLIGHT HELP/MEATS CUT				
EXTENSIVE ASSIST				
TOTAL ASSIST				
<b>CURRENT WEIGHT</b>				
<b>WEIGHT CHANGE</b>				
<b>FOOD &amp; FLUID CONSUMED @ MEALS</b>				
0-25% 25-50% 50-75% 75-100%				
<b>TOTAL DAILY MEALTIME FLUID INTAKE</b>				
<b>SUPPLEMENT INTAKE</b>				
<b>PROBLEMS IN</b>				
CHEWING				
SWALLOWING				
CHOKING				
DENTITION				
ASPIRATION				
<b>ADAPTIVE EATING DEVICES? (SPECIFY)</b>				
<b>APPETITE CHANGE? ( Y OR N )</b>				
<b>MENTAL/EMOTIONAL                      MMSE</b>				
DISRUPTIVE				
WANDERS				
OTHER				
<b>LAB DATA</b>				
HGB				
BUN				
GLUCOSE				
ALBUMIN				
NA, K+				
CHOLESTEROL				
OTHER				
<b>POTENTIAL CONDITIONS                      BRADEN</b>				
SKIN INTEGRITY				
EDEMA				
CONSTIPATION				
DIARRHEA				
NAUSEA				
ANOREXIA				