REGISTERED DIETITIAN PEDIATRIC ASSESSMENT

Client Surname:	**Client Given Name:**
DOB *(dd/mm/yy)*: **Gender:** ☐ M ☐ F	**Therapist:**
Address	**Initial Contact Date** *(dd/mm/yy)*:
	First Visit Date *(dd/mm/yy)*:
	Funder Info:
	Client ID:
Two Identifiers Used to Confirm Client Identity : ☐ Client Name ☐ DOB ☐ Other	
Phone:	**Accommodation:** ☐ House ☐ Apartment ☐ Other:
Client Lives with: ☐ Parent/s ☐ Foster ☐ Family ☐ Others:	
Concurrent Services ☐ Nursing ☐ OT ☐ PT ☐ PSW ☐ SLP ☐ SW	
Funding Sources: ☐OW ☐ OHIP ☐ ODSP ☐ ACSD (Assistance for Children with Severe Disabilities) ☐ Other:	

Appointments/Time Preference:	
Client Identified Issue	**What is the most important thing I can do today?**
MEDICAL ASSESSMENT	
Diagnosis/Reason for Referral	**Surgery/Procedures/Tests (VFSS)**
Relevant Medical History ☐ See referral ☐ Client ☐ Parent/Caregiver ☐ Consent to Assess ☐ Diabetes	
Feeding position and posture	**Oral, gross and fine motor skills**
Self- Care Abilities & Strengths Resources: ☐Parents ☐Family ☐Caregiver ☐Community ☐Friends ☐Other: Cultural Preferences, Values and Beliefs: Estimated # of visits	
Medication Client has: More than 5 meds? ☐Yes ☐ No Med changes in past 3 months> ☐ Yes ☐ No More than 2 prescribers for meds? ☐ Yes ☐ No If 2 or more are checked: Refer client to family physician/pharmacist for Medication Reconciliation	
Vitamin/herbal products	***Drug/Nutrient Interactions/Implications***
Pharmacy	**Lab Values**

REGISTERED DIETITIAN ASSESSMENT

Client Surname:_____ Client Given Name:_____

DOB (dd/mm/yy):_____ Therapist: _____

Health

ANTHROPOMETIC DATA ☐ See Growth Chart Corrected age:_____

Weight:	Percentile for weight/age:	BMI:	Goal:
Height/length:	Percentile for length/age:	History:	

DIET/DIET HISTORY ☐NPO ☐ Oral nutrition ☐ NG tube ☐ G tube ☐ J tube ☐ Breast Fed ☐ Formula Fed

Intake recall/Record, Formula Rx, Frequency, Volume, Regimen/Rate

☐Thickened formula

Food consistency ☐Exclusive tube feeding

☐Pureed ☐ Minced & Moist ☐ Soft and bite-sized ☐ Regular ☐ Commercially available ☐ Homemade ☐ N/A

BEHAVIOURAL ASSESSMENT

Food Refusal Behaviours (throwing, tantrums, closed mouth, gagging)

Possible causes of aversion ☐N/A
☐ Fear of eating ☐ Negative eating experiences
☐ Force Feeding ☐ Long-term nothing by mouth
☐ Lack of eating skills ☐ Other:

Relationship with food (reactions, proximity, role of food, playing)

Feeding dynamics (role of parent and child at mealtime)

Patient food preferences (likes and dislikes)

Mealtime environment

SENSORY ASSESSMENT

Food sensitivity by type of food or texture

Signs of hypersensitivity ☐ N/A
☐ Lack of eating skills ☐ Other
☐ Smell: coughing, gagging, turning head, covering nose, eyes water
☐ Tactile: batting food away, grimace, finger or lip splay
☐ Taste: gagging, vomiting, shuddering
☐ Auditory: coveres ears, startled by noises, rapid blinking

Signs of hyposensitivity ☐ N/A
☐ Loses food in mouth/ pocketing ☐ Lake of chewing
☐ Swallows large amounts of food ☐ Lacks facial expression
☐ Prefers strong flavours ☐ Low response to pain
☐ Touches people or objects frequently

SCREENING

Home Safety Hazard Screen: ☐ None unless specified below: Indoor Safety Concerns (e.g. stairs, lighting, frayed electrical cords etc.
☐ No ☐ Yes _____
Outdoor Safety Concerns (e.g. walkways, stairs etc.)
☐ No ☐ Yes _____

Accessibility Concerns: ☐ No ☐ Yes:_____
Sharps Management: N/A ☐No ☐ Yes:_____
Infections:☐ Yes ☐ No ☐ Unknown: _____
↓Immunity: ☐Yes ☐No ☐ Unknown
Client at Risk for/from: Roaming Imminent Physical Risk
Kinship relationships None Other:_____

Smoke Alarm: Yes No Portable Heaters: Yes No
Fire Extinguisher: ☐ Yes ☐ No
Storage of Oxygen containers ☐ N/A ☐ No
Pets: ☐ No ☐ Yes _____
Environmental Health (Infestation, mold, sanitation etc.)
☐ No ☐ Yes _____
ERL Code: 1 2 3 4 5
Emergency plan: ☐ No ☐ Yes:_____
Concerns raised with: ☐ Funder ☐ Client/Caregivers ☐ SE
☐ Education: Review Client Care & Safety handbook

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Health

CLINICAL INDICATORS (check all that apply)

Appetite: ☐Poor ☐ Fair ☐ Good ☐ Very Good	☐Nausea/Vomiting:
☐Chewing/Dentition:	☐Food allergies/intolerances:
☐Dysphagia:	☐Anorexia:
☐Diarrhea/Constipation:	☐Wet diapers/urination:
☐GERD (gastroesophageal reflux disease)	☐Other:
How often do you cough, choke or have pain when swallowing food or fluid? ☐ Often ☐ Sometimes ☐ Rarely ☐ Never	
Respiration with food or fluid ☐ N/A ☐ Change in breathing ☐ Noisy Breaths ☐ Signs of distress	Other Feeding Red Flags ☐ N/A ☐ Arching back, neck or head ☐ Vomiting ☐ Gagging ☐ Spitting ☐ Refusal
Pacing of Food ☐ N/A ☐ Too Fast ☐ Too Slow ☐ Adequate	Volume of food ☐ N/A ☐ Too much ☐ Too little ☐ Adequate
Bottle Feeding Observation ☐ N/A ☐ Uncoordinated; doesn't initiate sucking ☐ Starts well; fatigues quickly ☐ Weak ineffective sucking ☐ Oral loss/ spillage ☐ Pauses w/feeding	
Comments:	

FUNCTIONAL ABILITY/GENERAL-PHYSICAL SIGNS

Cognition: ☐ Intact ☐ Concerns	Feeds Self / Assisted:
Communication: ☐ Intact ☐ Concerns	Hearing:
☐ No dysfunction ☐ Difficulty with ambulation	Sight:
Edema: ☐ No ☐ Mild ☐Moderate ☐Severe ☐ Ascites	Concerns for skin breakdown: ☐ Yes ☐ No If Yes: ☐
Muscle wasting: ☐No ☐Mild ☐Moderate ☐ Severe	If Yes: ☐ Funder Notified ☐ Funder aware (Stage 1 2 3 4) Details:
Comments:	Comments:
NUTRIENT REQUIREMENTS Cite reference for calculation used	**NOTES: CURRENT NUTRITIONAL INTAKE** Compared to Needs
Energy	
Protein	
Fluid	
Other	
Stress Factor: Surgery (1.0-1.3) Infection (1.0-1.6) Trauma (1.3-1.6) Cancer (0.8-1.5) Other *(details):*	
Activity Factor: Sedentary (1.0-1.4) Sedentary/Light Activity (1.4-1.6) Moderate (1.6-1.8) Other *(details):*	

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Health

EQUIPMENT

Name of Equipment ☐ See CIF ☐ See Admission Report ☐ N/A	Funder Rental	Expiry Date	Client Owned	Purchased/ Private Rental	Pick-up Request
Equipment Funding Issues: ☐ No ☐ Yes ADP: ☐ No ☐ Yes	Funder Rental Policy Explained: ☐ Yes ☐ No				

Nutrition Diagnosis (Problem)	**Related To** (Etiology)	**As Evidenced By** (Signs and Symptoms)

REGISTERED DIETITIAN'S IMPRESSION

SGA Risk: ☐ A - Well Nourished ☐ B - Mildly/Moderately Malnourished ☐ C - Severely Malnourished

Analysis/Goals/Care Plan ☐ See Funder Report

Client/caregivers preferences are different from recommendations. ☐ Goals were developed in collaboration with client and family

Patient's motivation/readiness to change ☐ Not ready ☐ Getting ready ☐ Ready ☐ Action (<6m) ☐ Maintenance (>6m)

INTERVENTION

☐ Education ☐ Counseling ☐ Other services ☐ Strategies

☐ Plan developed in collaboration with client ☐ Consent to treatment/ intervention/ action plan obtained

☐ Care Plan Meets Funder Service Plan ☐ Reviewed patient right and responsibilities and privacy policy

☐ Others involved in plan:

Dietitians of Canada/PEN Handouts

Healthy Eating Guidelines:

☐ For increasing energy and protein intake ☐ *Other:*

☐ For feeding your baby solids ☐ sample meal plans ☐ For Increasing your child's iron intake

☐ Tips on feeding your picky toddler and preschooler

Specific Recommendations Discussed

☐ Nutrient Food Sources ☐ Nutritional Supplements ☐ *Other:*

☐ Meal Preparation Tips ☐ Canada's Food guide: ☐ Label reading

☐ Small frequent meals ☐ Proximity to food/ pre-feeding readiness

Resources that will be accessed to assist client to achieve goals

☐ Therapist Past Clinical Experience ☐ SE Practice/Client Tool Kit ☐ Guidelines/Standard Position Statement ☐ Best Practice Guidelines ☐ Clinical Leadership ☐ Other:

Before I go, is there something you would like me to do for you?

DISCHARGE PLANNING ☐ Discharge plan developed with client and family

☐ No further intervention planned ☐ Follow up with dietitians # visits planned:

☐ Refer to physician forfurther assessment ☐ Refer to community agency/program (*Specify):*

Other:

Therapist Signature	**Date** *(dd/mm/yy)*