REGISTERED DIETITIAN ASSESSMENT

Saint Elizabeth
Well beyond health care

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:
Client Identifiers : ☐ **Client Name** ☐ **DOB** ☐ **Other**	
Phone:	**Concurrent Services** ☐ Nursing ☐ OT ☐ PT ☐ PSW ☐ SLP ☐ SW
Client Lives with: ☐ Alone ☐ Spouse ☐ Children ☐ Others:	**Accommodation** ☐ House ☐ RH/LTC ☐ Apartment ☐ Other:
Employment Status ☐ Employed ☐ Unemployed ☐ Homemaker ☐ OW ☐ Retired ☐ Student	
Funding Sources: ☐ OW ☐ ODSP ☐ Veteran ☐ WSIB ☐ ACSD (Assistance for Children with Severe Disabilities)	

Appointments/Time Preference:

Client Identified Issue:

What is the most important thing I can do today?

Diagnosis/Reason for Referral	**Surgery:**

Relevant Medical History ☐ see referral ☐ Client ☐ Caregiver ☐ Consent to Assess ☐ Diabetes

Self- Care Abilities & Strengths

Resources: ☐ Family ☐ Caregiver ☐ Community ☐ Friends ☐ Other:

Cultural Preferences, Values and Beliefs:

Estimated # of visits

Medication:

Client has: ☐ > 5 meds ☐ Med changes in past 3 months ☐ More than 2 prescribers for meds

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:**

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ANTHROPOMETIC DATA

Weight	UBW:	IBW:	Goal:
Height:	History:		BMI:

DIET/DIET HISTORY

Special Considerations
(Intake Recall/Record; Formula Rx, Frequency, Volume, Regime/Rate)

Fluid Intake:
☐ less than 2 cups (0) ☐ 3-4 cups (2) ☐ ≥8 cups (4)
☐ about 2 cups (1) ☐ 5-7 cups (3)

Alcohol/Tobacco/Street Drugs

Nutritional Supplement(s) :

Do you usually cook your own meals? ☐Yes ☐No

Planning/Preparation:
☐ Self ☐ Family ☐ Other:

Shopping/Supplies

Financial

SCREENING

Skin Integrity
Has the client reported or have you observed concerns that may indicate a risk for skin breakdown: ☐ No ☐ Yes
If Yes → ☐ Funder Notified ☐ Funder Aware Plan For Follow-up:
☐ pressure ulcer stage 1 2 3 4 ☐ granuloma/g-tube site ☐ ulcers

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 ☐Yes
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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CLINICAL INDICATORS (check all that apply)

Appetite: ☐ Poor(0) ☐ Fair (4) ☐ Good (6) ☐ Very good (8)	
☐ Chewing/Dentition:	☐ Nausea/Vomiting:
☐ Dysphagia:	☐ Anorexia:
☐ Dry/Sore Mouth:	☐ Taste:
☐ Diarrhea/Constipation:	☐ Other:
☐ GERD (gastroesophageal reflux disease)	☐ Other:
How often do How often do you cough, choke or have pain when swallowing food or fluid? ☐Often (0) ☐Sometimes (2) ☐Rarely (6) ☐Never (8)	
Comments:	

FUNCTIONAL ABILITY/GENERAL-PHYSICAL SIGNS

Cognition:	Feeds Self / Assisted:
Interpreter/Primary Language:	Hearing:
Reads/Writes English/ESL:	Sight:
Previous Education:	☐No dysfunction ☐ Difficulty with ambulation
Edema: ☐No ☐Mild ☐Moderate ☐Severe ☐Ascites	Muscle wasting: ☐No ☐Mild ☐Moderate ☐Severe
Comments:	
Falls Risk: Client has: ☐ Fallen in the last 90 days ☐Afraid of falling ☐More than 4 meds If ≥2 are checked: ☐ referred to funder to report falls risk	

NUTRIENT REQUIREMENTS Cite reference for calculation used	**NOTES : CURRENT NUTRITIONAL INTAKE** Compared to Needs
Energy	
Protein	
Fluid	
Fibre	
Stress Factor: ☐Surgery ☐Infection ☐Trauma ☐Cancer ☐Other *(details):*	
Activity Factor ☐Sedentary ☐Moderate ☐Active ☐Other *(details):*	

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				
Funders: ☐ODSP ☐ CPP Disability ☐WSIB # ☐Private Insurance ☐ Veteran's Affairs					

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Nutrition Diagnosis (Problem)	**Related To:** (etiology)	**As Evidence By:** (signs and symptoms)

REGISTERED DIETITIAN'S IMPRESSION

SGA Risk: ☐ Low ☐Medium ☐ High

Analysis/Goals/Careplan ☐ See Funder Report

☐Goals were developed in collaboration with client and family

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 rights and responsibilities and privacy policy
☐ Others involved in plan:

Dietitians of Canada/PEN Handouts
Healthy Eating Guidelines
☐ For People with CHF ☐ *Other:*
☐ For increasing energy and protein intake
☐ To improve blood cholesterol
☐ For people taking Warfarin
☐ For those with chewing difficulties

Specific Recommendations Discussed
☐ Small frequent meals ☐ Canadian Diabetes Association Handouts: ☐ Fluid Restriction
☐ Meal Preparation Tips ☐ Nutritional Supplements
☐ Label reading ☐ Canada's Food guide: ☐ lower sodium food choices
☐ Heart to Home catalogue for frozen dinners ☐ Heart and Stroke Foundation Recipes
☐ *Other:*

Nutrition Monitoring and Evaluation
Indicator: Criteria:

Resources that will be accessed to assist client to achieve goals:

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

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

Self-management: What is your confidence that you can implement nutrition plan?
No confident 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Very Confident

DISCHARGE PLANNING ☐ Discharge plan developed with client and family

☐ No further intervention planned ☐ Follow up with dietitians # visits planned:
☐ Refer to physician for further assessment ☐ Refer to community agency/program (*Specify):*
☐ Other:

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