Nutrition Screening Form

Patient Name *(Last Name, First Name Middle Initial)*		*Date*	
		eFIND #	
Pod #		*Room #*	

Appetite History (mark 'X' where applies)		**Weight Loss History** (mark 'X' where applies)			
		Recent weight loss?		**Reason for weight loss?**	
Good (75-100% of meals)		*Yes*		*Intentional*	
Fair (50-75% of meals)		*No*		*Unintentional*	
Poor (<50% of meals)					

Chewing/Swallowing Difficulties? (mark 'X' where applies)		**Cultural/Religious Food Preferences** (mark 'X' where applies)			
Yes		*Vegan*		*No Pork*	
		Vegetarian		*Kosher*	
No		*Other*		*None*	

Describe 'Other' Cultural or Religious Food Preferences	

Food Allergies (mark 'X' where applies)					
Gluten/Wheat		*Fish/Shellfish*		*Peanut/Tree Nut*	
Lactose Intolerant		*Other*		*NKFA*	

Describe 'Other' Food Allergies If Applicable	

***** For Nutrition Operations Personnel Only ***** (mark 'X' where applies)		
Did patient report Fair or Poor 'Appetite History'?	*Yes*	
	No	
Did patient report Recent and Unintentional 'Weight Loss History?'	*Yes*	
	No	

If patient answered 'Yes' to both questions above, refer patient to RD.

Name of NDTR providing screening	**Name of patient's assigned RD**