

HSCL NUTRITION ASSESSMENT

Name:		PARIS ID:
DOB:	Age:	PHN:
Gender:		Phone:
Home Address:		

Assessment Start Date: **Assessment End Date:** **Carried Out By:**

Allergies - Current

A / S	Date Entered	Allergen	Reaction	Comment
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Medications

Please see Medication Section in PARIS or Medication/Treatment Orders-Recommendation report for further details. (eg. medications in home?, Confirmed (written order received?))

Medication	Route	Dose	Frequency	Start Date	End Date	Comments
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Growth Chart

Date Measured	Age	Weight kg %ile	Height cm %ile	BMI %ile	Head Circumference cm %ile	% Birth Wgt Lost	Wgt for Length %ile	Waist Hip cm ratio
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Assessment

Possible Nutr Rx Interaction:

Usual Weight: Ideal Body Weight:
 Current Diet:
 Nutr. Supplement:
 Preferences:
 Fluid Intake:
 Bowel Function:
 Appetite:
 Chewing:

HSCL NUTRITION ASSESSMENT

Name:	PARIS ID:
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Hearing:
Comprehension:
Dexterity:
Feeding Aids:
Swallowing:
Teeth/Dentures:
Vision:
Mobility:
Feeding Ability:
Other:
Kcal Requirements:
Protein Requirements:
Fluid Requirements:
Mental Functioning/Mood:
Relevant Labs:
Nutrition Risk Factors:

Nutrition Risk Status:

Assessment:

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments
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Needs

Need	Post to C/P	Processed	Comments
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Casenote

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- End of Report -----