



Department of  
Veterans Affairs

**NUTRITION STATUS CLASSIFICATION WORKSHEET**

SECTION A. NUTRITION HISTORY					SECTION B. UNINTENTIONAL WEIGHT LOSS				
<b>SECTION C. % IDEAL BODY WEIGHT</b>					<b>Unintentional Weight Loss Ratings</b>				
<b>% Ideal Body Weight Scores</b>									



## FOREWARD

These instructions outline a tool clinical dietetic staff will use to identify the nutrition status of patients. For optimal patient care and efficient use of clinical staff time, it is important to identify, as quickly as possible, patients most likely to benefit from nutrition interventions. Use of the Nutrition Status Classification Scheme results in a "point in time" determination of nutrition status. The determination of nutrition status is based on seven commonly accepted indicators usually available at the time a nutrition screen or assessment is completed. A nutrition status can be determined for either inpatients or outpatients.

The seven indicators used in this Nutrition Status Classification Scheme evolved from: (1) an extensive literature search for parameters commonly used to assess nutrition status; (2) a review of practices within the VA system; and (3) the clinical expertise of the Clinical ad hoc Group. Results of field testing the Classification Scheme for reliability and validity support the use of the Nutrition Status Classification Scheme for determination of a patient's nutrition status among practitioners within a facility and between institutions. However, achievement of reliability and validity ***requires the classification scheme to be applied as outlined in these instructions***. If a facility wishes to use the nutrition status of patients for assigning workload or for comparison purposes within a facility or among facilities, using the Nutrition Status Classification Scheme as outlined is essential.

Appreciation is extended to all those who have contributed to the development of this classification scheme. Success in its application will depend on consistent interpretation of the guidelines by each practitioner. An annual review of the guidelines by each practitioner is recommended. Questions and/or suggestions for future revisions may be directed to a member of the Clinical ad hoc Group at any time.

Bernice Dorse, R.D.  
Director, Dietetic Service

The following people are acknowledged for their contributions to the development of these instructions:

The Clinical ad hoc Group of the Dietetic Service DHCP Expert Panel

Lynn Hiller, M.S., R.D., Chairperson  
James A. Haley VA Hospital  
Tampa, FL (700) 822-6011

Mary Ehret, R.D., L.D.  
Chillicothe VAMC  
Chillicothe, OH (700) 975-7511

Jeanne Myscofski, R.D.  
Edward Hines VA Hospital  
Hines, IL

Catherine Austin, M.S., R.D.  
Carl T. Hayden VAMC  
Phoenix, AZ (700) 761-7411

Margie Rodriguez, M.S., R.D.  
San Antonio VAMC  
San Antonio, TX (700)779-5118

Peggy Jernigan, M.S., R.D.  
Seattle VAMC  
Seattle, WA (700) 396-2043

Laurel Van Halderen, R.D.  
Carl T. Hayden VAMC  
Phoenix, AZ

Rita Kleypas, R.D.  
Olin E. Teague VAMC  
Temple, TX (700) 760-4811

Connie Faluszczyk, M. Ed., R.D.  
Erie VAMC  
Erie, PA (700) 726-6614

Dietetic Service Clinical Staffing Task Force

Betty L. Beach, Ph.D., R.D., Chairperson  
Omaha VAMC  
Omaha, NE (700) 860-3508

Maryann Shavink-Dillerud, M.S., R.D.  
Portland VAMC  
Portland, OR (700) 424-5991

Charlotte Roberts, R.D.  
West Los Angeles VAMC  
Los Angeles, CA (310) 824-3150

The Department of Veterans Affairs

Carole J. Shore, M.S., R.D., L.D.  
Dietetic Service  
Department of Veterans Affairs  
Washington, DC (202) 535-7260

Great Lakes Health Services Research  
and Development Field Program

Julie Lowery, Ph.D.  
Jenny Davis, M.H.S.A.  
Great Lakes HSR&D Field Program  
Ann Arbor VAMC  
Ann Arbor, MI

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## 1.0 INTRODUCTION

The purpose of this document is to provide instructions on use of the V.A. Nutrition Status Classification Scheme. The scheme was developed for use by clinical dietetic staff to identify the nutrition status of a patient. Nutrition status should indicate patients most likely to benefit from nutrition intervention. In addition, the degree of nutritional compromise assists the clinician in prioritizing work load.

Clinical dietetic practitioners have long recognized the need for a systematic method of prioritizing patients for nutrition care. Various attempts have been made to categorize clientele using level of care or levels of nutrition risk. No one system has been accepted universally within the VA. The Clinical ad hoc Group (CAHG) was charged with developing a tool which would be reliable and valid in the classification of patients requiring nutrition care and which would be applicable in all settings. The Nutrition Status Classification Scheme presented in these instructions is the result of their efforts. The following discussion reflects the rationale behind the development of the Nutrition Status Classification Scheme, how it is to be used, and clarification of terminology.

### Nutrition Status Versus Level of Care

*Levels of care* have been used widely in an attempt to reflect the demand on resources. Usually, three to four levels are described, assuming a direct relationship to resources: the higher the level, the more resources required.

*Nutrition status* defines the patient's nutrition condition at a "point in time". The patient's nutrition status, along with further assessment and local policy will determine the priorities for nutrition intervention. The Clinical Dietetic Staffing Study presently underway will determine the relationship between nutrition status and level of care as defined by services performed and resources required.

### Compromised Versus At Risk

Patients who are determined to be at a nutrition status other than "normal" nutrition status HAVE SOME DEGREE OF NUTRITIONAL COMPROMISE or HAVE PARAMETERS THAT REQUIRE INTERVENTION. In other words, they are BEYOND being "At Risk" and in fact ARE nutritionally compromised to some degree. It may be helpful to consider that ANY patient who is determined to be a nutrition status other than Status I - normal - has SOME degree of nutritional

compromise: Status II is mild, Status III is moderate, and Status IV is severe. On the other hand, the term "RISK" implies that there is currently NO compromise - only a potential to develop it. A patient who is determined to be a Status IV would BE compromised and NOT just be "at risk". A Status II patient is mildly compromised, not "at risk".

### Nutrition Screening Versus Nutrition Assessment

The difference between screening and assessment can be blurred, especially if the same person is responsible for completing both activities for a patient. Screening and assessment can be accomplished in two separate steps or in some cases may be done concurrently. It may help to consider that the outcome of screening is to determine a nutrition STATUS and to help PRIORITIZE workload. Outcomes of assessment are identification of: the presence and degree of malnutrition; the need for nutrients; and, whether or not those needs are being met. An assessment leads to a nutrition care plan which includes nutrition intervention, nutrition education and frequency of monitoring.

It would be appropriate to complete screening separately when a large number of admissions need to be evaluated to prioritize their care. Later, a more complete assessment may be done on those patients with the greatest nutritional compromise. An assessment is usually not required for patients who are determined to be at normal nutrition status. Only a brief assessment may be required for patients who are mildly compromised.

*Nutrition screening* is the process of gathering pre-established data from the medical record, computer or by brief patient interview, followed by evaluation of the collected data to determine if the patient is nutritionally compromised. The preferred sources of data to use when using the Nutrition Status Classification Scheme for admission screening are:

- DHCP Nutrition Screen
- DHCP Nutrition Profile
- A Brief Patient Interview

The purpose of this process is to identify the patient's nutrition condition or status. Descriptive patient criteria for each indicator are provided by the Nutrition Status Classification Scheme to categorize patients into groups according to the degree of nutritional compromise. This process is usually accomplished within three working days of admission.

Screening may also occur when a patient is transferred from one setting to another. Also, a re-screen may be conducted when a patient remains in the hospital for a prolonged period of time. The re-screening process is the opportunity to gather updated information. The additional or more recent information (i.e., updated diagnosis, recent laboratory data or diet order changes) may warrant an adjustment to the assigned nutrition status.

*Nutrition assessment* is the process of more in-depth evaluation of patient data. Results are used to formulate a nutrition classification category based on local policy and ICD-10-CM classification system, confirm or re-assign the nutrition status classification, identify the need for further assessment and nutrition care interventions, and state the intended follow-up schedule. Sources of data for nutrition assessment are:

- Routine patient interview
- Medical record review
- Consultation with other health care team members

Assessment may include the evaluation of nutrient requirements and/or nutrient distribution, adequacy of nutrient composition of current diet, frequency of monitoring after the initial assessment, the need for education and counseling on diet and nutrition, and the patient's nutritional needs in preparation for discharge. The results of the assessment justify the nutrition care plan.

Assessments are usually completed by the clinical Registered Dietitian (R.D.). In some cases where only a limited or very brief assessment is required, it may be completed by the clinical Dietetic Technician (D.T.). Normally, assessments are completed one to three days after a screen.

## Instructions for Use

The Nutrition Status Classification Scheme has been determined to be a valid and reliable tool. One hundred-twenty dietitians and dietetic technicians representing 98 VA medical centers participated in this process. These instructions are the result of this effort. However, the scheme must be used as outlined for the classification of nutrition status to be valid and reliable when compared among fellow practitioners and between hospitals. For additional information on the clinical criteria used for developing the Nutrition Status Classification Scheme, a list of references is included in Appendix A.

**IT IS VERY IMPORTANT THAT EACH PRACTITIONER CAREFULLY STUDY THE INSTRUCTIONS TO INSURE THAT THE NUTRITION STATUS CLASSIFICATION SCHEME IS USED AS INTENDED.**

Please remove Table 1, the Nutrition Status Classification Scheme (page 5). Refer to it as you carefully study the following explanations for the components of the Nutrition Status Classification Scheme. Numbers and letters are used to cross-reference the explanation with the table.

**WHILE YOU ARE STUDYING THESE INSTRUCTIONS, RECORD YOUR QUESTIONS/COMMENTS ON FORM A (Pg. 7). AFTER COMPLETING YOUR STUDY OF THESE INSTRUCTIONS, AND BEFORE COMPLETING THE PRACTICE SCENARIOS, REVIEW YOUR QUESTIONS AND COMMENTS WITH YOUR SUPERVISOR.**

**TABLE 1  
NUTRITION STATUS CLASSIFICATION SCHEME**

INDICATORS	I NORMAL NUTRITION STATUS	II MILDLY COMPROMISED NUTRITION STATUS	III MODERATELY COMPROMISED NUTRITION STATUS	IV SEVERELY COMPROMISED NUTRITION STATUS
	①	②	③	④
A. Nutrition History	<ul style="list-style-type: none"> <li>- Appetite, good</li> <li>- Eating/digestion problems, none</li> <li>- Independent activities of daily living</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, fair</li> <li>- Chewing problems</li> <li>- Constipation</li> <li>- Limited activities of daily living</li> <li>- Nausea</li> <li>- Requires feeding assistance</li> <li>- Restricted ambulation</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, poor</li> <li>- Diarrhea</li> <li>- Swallowing problems</li> <li>- Vomiting</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, none</li> </ul>
B. Unintentional weight loss as % of usual body weight.	Stable Weight(no weight loss)	< 10% - 6 mos.	10-15% in 6 mos. OR <7.5% in 3 mos. OR <5% in 1 mon. OR <2% in 1 wk.	>15% in 6 mos. OR > 7.5% in 3 mos. OR > 5% in 1 mon. OR > 2% in 1wk.
C. Weight as % of ideal body weight (IBW)	100 - 90% IBW <b>OR</b> < 119% IBW	89 - 81% IBW <b>OR</b> 120 - 129% IBW	80 - 75% IBW <b>OR</b> 130 - 149% IBW	< 74% IBW <b>OR</b> > 150% IBW
D. Diet	<ul style="list-style-type: none"> <li>- Mechanical</li> <li>- Regular</li> </ul>	<ul style="list-style-type: none"> <li>- ADA/Wt. Red.</li> <li>- Any consistency other than mechanical</li> <li>- Drug-Nutrient Interaction</li> <li>- Dysphagia</li> <li>- Lactose Free</li> <li>- Low Fat/Low Cholesterol</li> <li>- Sodium Restricted</li> </ul>	<ul style="list-style-type: none"> <li>- Fluid Restricted (&lt; 1000 cc)</li> <li>- Mineral Restricted other than Sodium</li> <li>- Protein Restricted</li> <li>- Tube feeding, stable</li> </ul>	<ul style="list-style-type: none"> <li>- Cl. Liq. &gt; 3 days</li> <li>- NPO &gt; 3 days</li> <li>- PPN</li> <li>- TPN</li> <li>- Tube feeding, unstable</li> </ul>
E. Diagnosis	<ul style="list-style-type: none"> <li>- All others including surgeries not mentioned</li> <li>- Dehydration</li> <li>- Electrolyte imbalance</li> <li>- F/U post surgery</li> <li>- HIV +</li> <li>- HTN</li> <li>- Psychological disorders</li> <li>- Total hip replacement</li> </ul>	<ul style="list-style-type: none"> <li>- Alcohol abuse</li> <li>- Alzheimer's disease</li> <li>- Amputation</li> <li>- Angina</li> <li>- Cancer (except GI tract, head &amp; neck)</li> <li>- Cardiac disease</li> <li>- COPD, stable</li> <li>- CVA</li> <li>- Dementia</li> <li>- Diabetes, controlled</li> <li>- Drug abuse</li> <li>- Fracture, other</li> <li>- GI disease, other</li> <li>- Neurological disorders, other</li> <li>- Nutritional anemia</li> <li>- Pneumonia</li> <li>- Pressure ulcer, stage I or II</li> <li>- Psychological eating disorder</li> <li>- PVD</li> <li>- Radiation therapy (except GI tract, head &amp; neck)</li> <li>- Renal disease</li> <li>- Substance abuse</li> <li>- Tuberculosis</li> </ul>	<ul style="list-style-type: none"> <li>- AIDS</li> <li>- Burns (&lt; 25% BSA)</li> <li>- Cancer involving GI tract or head &amp; neck</li> <li>- Cardiomyopathy</li> <li>- Chemotherapy</li> <li>- Congestive heart failure</li> <li>- COPD, unstable</li> <li>- CHF</li> <li>- Chronic renal failure</li> <li>- Diabetes, uncontrolled</li> <li>- Diabetes, new diagnosis</li> <li>- Dysphagia</li> <li>- Fracture, traumatic</li> <li>- GI disease w/ malabsorption or maldigestion</li> <li>- Hepatic disease</li> <li>- Infection w/fever</li> <li>- Neurological coma</li> <li>- Pressure ulcer, stage III</li> <li>- Pulmonary disease, O2 dependent</li> <li>- Radiation therapy for GI tract, head &amp; neck</li> <li>- SCI, new</li> <li>- Transplantation, major organ, stable</li> </ul>	<ul style="list-style-type: none"> <li>- Acute renal failure</li> <li>- Burns (&gt;25% BSA)</li> <li>- Cachexia</li> <li>- Failure to thrive</li> <li>- GI obstruction</li> <li>- Hepatic coma</li> <li>- Hepatic encephalopathy</li> <li>- Ileus</li> <li>- Malnutrition</li> <li>- Multiple trauma</li> <li>- Multi-system organ failure</li> <li>- Peritonitis</li> <li>- Pressure ulcer, stage IV</li> <li>- Pulmonary failure, ventilator dependent</li> <li>- Sepsis</li> <li>- Transplantation, major organ system, pre- and post-op</li> </ul>
F. Albumin (gm/dL) S.D. = Standard Deviations	> - 2 S.D.	- 2.3 S.D. < - 3.3 S.D.	- 3.6 S.D. < - 4.6 S.D.	< - 4.9 S.D.
G. TLC (cells/cmm)	> 1500	1499 - 1200	1199-800	< 799



**FORM A.**  
**QUESTIONS/COMMENTS ON NUTRITION STATUS INDICATORS**

As you review the instructions, make notes of questions and/or comments you would like to discuss with your supervisor.

NUTRITION HISTORY: \_\_\_\_\_

\_\_\_\_\_

UNINTENTIONAL WEIGHT LOSS: \_\_\_\_\_

\_\_\_\_\_

PERCENT OF IBW: \_\_\_\_\_

\_\_\_\_\_

DIET: \_\_\_\_\_

\_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

\_\_\_\_\_

LAB VALUES: \_\_\_\_\_

\_\_\_\_\_

ALBUMIN: \_\_\_\_\_

\_\_\_\_\_

TLC: \_\_\_\_\_

\_\_\_\_\_

CLASSIFICATION OF OVERALL NUTRITION STATUS: \_\_\_\_\_

\_\_\_\_\_

NUTRITION STATUS CLASSIFICATION FORMULA \_\_\_\_\_

\_\_\_\_\_



## 2.0 DEFINITION OF NUTRITION STATUS

Four nutrition status classifications (refer to columns 1 - 4, Table 1) are used to define the nutrition conditions. These statuses are defined using *AVAILABLE VALID CRITERIA* as follows:

### ①. Normal Nutrition Status (I)

- Patient is NOT nutritionally compromised.
- Patient is considered nutritionally stable.
- Nutritionally related problems or indicators, which may exist, do not impact nutrition status.
- Patient will remain at this level unless a critical unforeseen event takes place.

### ②. Mildly Compromised Nutrition Status (II)

- The patient has some GENERAL or SLIGHT deterioration in nutrition status.
- A FEW nutritionally related problems or indicators exist which impact the patient's nutrition status.
- Patient is considered somewhat nutritionally unstable.
- Patient is anticipated to remain at this level or improve, unless a critical unforeseen event occurs.

### ③. Moderately Compromised Nutrition Status (III)

- The patient has SIGNIFICANT DETERIORATION in nutrition status.
- SEVERAL nutritionally related problems or indicators exist which directly impact the patient's nutrition status.
- The patient may be unstable, nutritionally or medically, due to his sub-optimal nutrition status.

**④. Severely Compromised Nutrition Status (IV)**

- The patient has OVERT nutrition deficiencies or MALNUTRITION or EXTREME DETERIORATION in nutrition status.
- MANY nutritionally related problems or indicators exist which have a profound impact on the patient's nutrition status.
- This patient is generally considered unstable, nutritionally and/or medically.

### 3.0 INDICATORS OF NUTRITION STATUS

Seven indicators of nutrition status (refer to rows A through G, Table 1) were selected as being most pertinent and likely available. Each of the seven indicators are further defined by descriptive patient criteria. Each indicator is defined by criteria as though on a continuum. Criteria CANNOT be interpreted as describing an equi-distance between each status.

**NOTE: WHEN DATA ARE NOT AVAILABLE FOR AN INDICATOR, DO NOT RATE -- i.e., LEAVE THE INDICATOR STATUS BLANK. IN THIS CASE, THE INDICATOR SHOULD NOT BE CONSIDERED IN THE OVERALL STATUS DETERMINATION.**

Patients are different and seldom “textbook” examples. Interpretation of the information may be required when evaluating the data. The following discussion of each indicator is provided to assist in use of the Nutrition Status Classification Scheme.

#### **(A) Nutrition History**

This indicator covers criteria which have had a recent impact on the patient’s ability to consume adequate nutrition. These include appetite changes, chewing or swallowing difficulties, gastrointestinal complaints and limitations in independence.

A patient may have a combination of criteria present that range from those considered normal nutrition status to severely compromised nutrition status. When this occurs, use the highest status rating for this indicator. The term "highest" refers to the most compromised or worst rating. Nutrition history information should ideally come from the patient; however, it may also be obtained from other reliable sources such as family, caregiver or nurse.

**INSTRUCTIONS FOR NUTRITION HISTORY:**

- Give "Today's" criteria/symptoms more priority than complaints of the past.
- Use the criteria/symptoms which yield the highest or most compromised rating.

**(B) Unintentional Weight Loss As A Percent Of Usual Body Weight**

To evaluate this indicator you need to consider the percent of usual body weight lost over the most recent time period available. First, determine if the patient has lost weight unintentionally during the past 6 months. If the patient has lost weight, determine: (1) the patient's usual weight prior to weight loss; (2) the patient's present (or most recent) weight; and (3) the length of time during which the weight loss occurred.

To calculate percent of usual body weight loss use the following formula:

$$\frac{\text{Usual Weight} - \text{Current Weight}}{\text{Usual Weight}} \times 100 = \% \text{ of Usual Body Weight Loss}$$

**See Appendix B for sample calculations.**

**INSTRUCTIONS FOR UNINTENTIONAL WEIGHT LOSS:**

- Leave the indicator BLANK if:
  - Patient has gained weight.
  - Weight loss is due to sensible dieting.
  - Weight loss is attributed to diuresis or amputations.
  - Weight data are greater than six months old.
- Consider weight loss that has occurred only in the last 6 months. (Weight loss which occurs over a period of time greater than 6 months may be used in the OVERALL rating of the patient's nutrition status.)
- If a patient's weight has been recorded more than once in the last 6 months, use the most recent weight loss for rating this indicator.
- If weight loss is noted and no statement is made regarding intention, consider it unintentional.
- Patients whose weight remains stable or unchanged should be rated I, Normal Nutrition Status.
- When current weight is not available for calculating weight loss, use the most recent weight.

**C.) Percent of Ideal Body Weight**

There are a variety of methods available for estimating Ideal Body Weight (IBW) such as the HAMWI Method, the Metropolitan 1959 tables, the Metropolitan 1983 tables, or special tables for spinal cord injury. To calculate percent IBW use the following formula:

$$\frac{\text{Current Weight}}{\text{IBW}} \times 100 = \% \text{ IBW}$$

See Appendix C for sample calculations.

The percentages used for each nutrition status are conservative since nutrition problems and complications can be seen before extreme deviations in percent IBW are evident.

**INSTRUCTIONS FOR PERCENT OF IDEAL BODY WEIGHT:**

- The patient's IBW should be adjusted for frame size prior to calculating the percentage.
- When not known, assume medium frame size.

**(D) Diet**

When rating this indicator, consider only the current diet that has been ordered. Generally, the more complex or restrictive a diet, the more likely the diet will be inadequate in some nutrients. The patient who requires a highly specialized diet may already have a compromised nutrition status. If your facility uses a "default" diet in DHCP and the default diet is the current diet order, LEAVE THIS INDICATOR BLANK. A "default" diet refers to the diet some hospitals automatically send upon admission until a diet is ordered as written.

**INSTRUCTIONS FOR DIET:**

Leave the indicator BLANK if, at the time of screening, any of the following is applicable:

- No diet has been ordered.
- Patient has been NPO for less than three days.
- Patient has been on clear liquid diet for less than 3 days.
- "Default" diet has been ordered.

**(E) Diagnosis**

When rating this indicator, use the most current diagnostic data that are available. An old diagnosis may no longer be "active" or pose a problem for the patient at this point. DO NOT try to extrapolate from a patient's laboratory data what other

medical diagnoses may be forthcoming. As additional diagnoses are identified due to confirmation of abnormal laboratory values, the rating for this indicator can change. Pertinent medical problems, including a **rule out** diagnosis, that impact the patient’s nutrition status should be considered. For patients with MORE THAN ONE diagnosis, use the diagnosis which yields the HIGHEST or most compromised status. The severity of a diagnosis must be considered in relationship to the progression or stage of the disease. DIFFERENT STAGES OF A DISEASE HAVE DIFFERENT STATUSES. Following are examples:

Renal Disease:

Status II: Chronic renal insufficiency  
Kidney stones

Status III: Chronic renal failure

Status IV: Acute renal failure

Cardiac Disease:

Status II: Coronary artery disease  
Angina  
R/O myocardial infarction  
Hyperlipidemia  
Hypercholesterolemia

Status III: Congestive heart failure  
Cardiomyopathy

Status IV: Cardiac cachexia

Gastrointestinal Disease:

Status II: Hiatal hernia  
Peptic ulcer disease  
Gastroesophageal reflux  
Gallstones  
Diverticulitis

Status III: Gastrointestinal bleeding  
Pancreatitis  
Crohn's disease  
Celiac disease  
Short bowel syndrome  
Ulcerative colitis  
Enteritis

Status IV: Gastrointestinal obstruction  
Ileus

Diagnoses listed in Table 1 are not all inclusive. **See Appendix D for a more complete listing of diagnoses.** This list will be updated periodically.

**INSTRUCTIONS FOR DIAGNOSIS:**

- Use the medical condition that yields the highest or most compromised rating.
- Remember that different stages of a disease have different statuses. If the exact stage or diagnosis is NOT noted in the Nutrition Status Table, use the closest one. If there is no close match, use your clinical judgment in assigning a rating.
- Rate a "rule-out" diagnosis the same as the diagnosis itself.

## **F.) Albumin**

Each medical center **MUST** calculate serum albumin levels for the four nutrition status levels. **Appendix E gives the instructions for doing this.** Insert calculated values into row F of the Nutrition Status Table provided in Appendix F, and reproduce this table for use at your facility. **USE THE ALBUMIN RANGES CALCULATED FOR YOUR FACILITY.**

A variety of non-nutritional factors may affect the patient's albumin level, including dilutional state, liver disease, sepsis, acute stress, and/or blood loss with replacement of packed red blood cells. You must evaluate the relevance of the albumin level in light of the presence of non-nutritive factors. It may be necessary to exclude albumin from the screening process. **DO NOT** consider an albumin level **OLDER THAN SIX WEEKS** as it may not reflect a patient's current nutrition status. In this situation, **LEAVE THE INDICATOR BLANK.**

### **INSTRUCTIONS FOR ALBUMIN:**

- Use only current laboratory results, less than six weeks.
- Use the albumin ranges calculated for your facility.

## **G.) Total Lymphocyte Count (TLC)**

A patient's TLC may be reflective of underlying nutrition status. A variety of non-nutritional factors may increase or decrease TLC. Some of these are cancer, chemotherapy, infection, anesthesia, AIDS and immunosuppressant medication. If any of these or similar factors exist that could be impacting on TLC, it may be necessary to **EXCLUDE** total lymphocyte count in the screening process. **DO NOT** consider a TLC **OLDER THAN SIX WEEKS** as it may not reflect a patient's current nutrition status. In this situation, **LEAVE THE INDICATOR BLANK.**

### **INSTRUCTION FOR TOTAL LYMPHOCYTE COUNT:**

- Use only current laboratory test results, less than six weeks.

**INSTRUCTIONS FOR INDICATORS:**

- **When no data are available, the indicator is left blank. The indicator should not be considered in the overall status determination when no data are available to rank the indicator.**
- **Table 2 (page 19) summarizes the instructions for rating the indicators and for assigning an overall nutrition status. You may want to remove this and carry it with you for reference.**



**TABLE 2.**  
**REMINDERS FOR USING THE NUTRITION STATUS CLASSIFICATION SCHEME**

Review all available patient information. Assign a rating (I, II, III, IV) to each indicator. Data not available, or outdated? Do not assign a value to the indicator. Leave it blank.

<b>Nutrition History:</b>	<p>Give "Today's" criteria/symptoms more priority than complaints of the past.</p> <p>Use the criteria/symptoms which yield the highest or most compromised rating.</p>
<b>Unintentional Weight Loss:</b>	<p>Leave indicator BLANK if:</p> <ul style="list-style-type: none"> <li>    Patient has gained weight.</li> <li>    Weight loss is due to sensible dieting.</li> <li>    Weight loss is attributed to diuresis or amputations.</li> <li>    Weight data are greater than six months old.</li> </ul> <p>Consider weight loss that has occurred only in the last 6 months. (Weight loss which occurs over a period of time greater than 6 months may be used in the OVERALL rating of the patient's nutrition status.)</p> <p>If a patient's weight has been recorded more than once in the last 6 months, use the most recent weight loss for rating this indicator.</p> <p>If weight loss is noted and no statement is made regarding intention, consider it unintentional.</p> <p>Patients whose weight remains stable or unchanged should be rated I, normal Nutrition Status.</p> <p>When current weight is not available for calculating weight loss, use the most recent weight.</p>
<b>Percent of IBW:</b>	<p>Adjust ideal body weight for frame size prior to calculating the percentage.</p> <p>If not known, assume medium frame size.</p>
<b>Diet:</b>	<p>Leave the indicator blank for the following: no diet order; NPO &lt; 3 days; clear liquid &lt; 3 days; "default" diet order.</p>
<b>Diagnosis:</b>	<p>Use the medical condition that yields the highest or most compromised rating.</p> <p>Remember that different stages of a disease have different statuses. If the exact stage or diagnosis is NOT noted in the Nutrition Status Table, use the closest one. If there is no close match, use your clinical judgment in assigning a rating.</p> <p>Rate a "rule-out" diagnosis the same as the diagnosis itself.</p>
<b>Albumin:</b>	<p>Use only current laboratory test results, less than six weeks.</p> <p>Use the albumin ranges calculated for your facility.</p>
<b>TLC:</b>	<p>Use only current laboratory test results, less than six weeks.</p>
<b>Assignment of Overall Status:</b>	<p>Rate only when there are data for 4 or more indicators.</p> <p>Do NOT average indicator ratings or assign the highest level received on an indicator as your overall rating of nutrition status. Use your clinical judgment in arriving at a value.</p> <p>Do NOT downgrade a patient's status due to palliative or supportive care.</p> <p>Consider all relevant data, including data not rated in the indicators.</p> <p>Do not try to anticipate future status of patient.</p>



#### 4.0 OVERALL CLASSIFICATION OF NUTRITION STATUS

After rating each indicator, an overall nutrition status must be determined. A patient may have indicators at various states of compromise. At this point, ALL relevant data, including data not rated in the indicators should be used. The overall status SHOULD NOT be a simple averaging or choosing the highest level assigned to a particular indicator. The final status should be based on the overall impression of the criteria and on clinical judgment as to the interrelationship of the indicators. The overall classification of nutrition status must be based upon data from at least 4 of the indicators.

When classifying the overall nutrition status, DO NOT TRY TO ANTICIPATE what may happen to the patient in the future, including such things as assuming a patient with poor PO intake will require a feeding tube. Classify the patient's *current* nutrition status. REMEMBER, as changes occur with the patient, changes can and should be made in the classification of nutrition status.

##### **INSTRUCTIONS FOR OVERALL NUTRITION STATUS:**

- **Rate only when there are data for 4 or more indicators.**
- **Do NOT average indicator ratings or assign the highest level received on an indicator as your overall rating of nutrition status.**
- **Do NOT downgrade a patient's status due to palliative or supportive care.**
- **Consider all relevant data, including data not rated in the indicators.**
- **Do not try to anticipate future status of patient.**
- **Use your clinical judgment in arriving at a value.**

## NUTRITION STATUS CLASSIFICATION FORMULA

A formula has been developed to assist in determining a patient's overall nutrition status. Table 3, Nutrition Status Classification Formula, was developed from the results of the Nutrition Status Reliability Study. The results of this study show that the use of the table gives reliable and accurate results in classifying the overall nutrition status of a patient. Use of this method is OPTIONAL. Any overall scores obtained from this method should be adjusted as necessary based upon clinical judgment.

**TABLE 3**  
**NUTRITION STATUS CLASSIFICATION FORMULA**

Instructions: Review the ratings assigned to each of the indicators. Identify the three ratings with the largest values (i.e., the most compromised ratings). (REMEMBER: you must have 4 or more indicators to determine an overall nutrition status.) Add the values of these top 3 ratings. This total value gives the overall nutrition status as follows:

Total value of top 3 indicator ratings	3-5	6-8	9-11	≥12
Overall Nutrition Status	I	II	III	IV

## **5.0 NUTRITION STATUS CLASSIFICATION WORKSHEET**

A worksheet has been developed to assist in assigning nutrition status ratings (I to IV) to each of the seven indicators. A summary of the instructions for rating each of the indicators is incorporated in the worksheet to facilitate the process of assigning a rating. You may notice that there are some differences between the worksheet and Table 1, "Nutrition Status Classification Scheme." The worksheet is designed to provide more detailed instructions for assigning ratings to the individual indicators.

Also note that, for each indicator, spaces are provided for two ratings: the actual rating determined from the descriptive criteria and an "adjusted rating." The adjusted rating is determined by the clinician using the descriptive criteria along with clinical judgment. The two ratings for a given indicator may or may not be the same. In assigning an overall nutrition status rating for a patient, clinical judgment should be used in considering the relative importance of the seven indicator ratings, both actual and adjusted.

It is recommended that you use this worksheet to become proficient at determining the nutrition status of patients using these guidelines. As you become more experienced using the Nutrition Status Classification Scheme, you will find that it is no longer necessary to use the worksheet to maintain the same level of proficiency.

Note: The Nutrition Status Classification Worksheet (Appendix G) should be updated to reflect the calculated serum albumin levels for your medical center and then be reproduced to meet your facility needs.



## **6.0 APPLICATION OF THE NUTRITION STATUS CLASSIFICATION SCHEME**

On pages 31 to 42 are completed example Scenarios A, B, and B1. Explanations of the classification of each indicator for all three scenarios are provided on pages 43-47 "Summary of Ratings for Example Scenarios". Materials needed to complete the scenarios are as follows:

Table 4 (p. 27): Normal Laboratory Values

Table 5 (p. 29): Nutrition Status Classification Scheme for Practice

Scenarios (**serum albumin levels to be used in these scenarios have already been calculated for each nutrition status**)

Nutrition Status Classification Worksheet (attached to each scenario)

### **INSTRUCTIONS FOR REVIEWING EXAMPLE SCENARIO A:**

- Example scenario A provides you with information which might be obtained from a DHCP nutrition screen, a DHCP nutrition profile and a brief patient interview.

### **INSTRUCTIONS FOR REVIEWING EXAMPLE SCENARIOS B and B1:**

- Example scenario B provides you with data received as part of the admission screening. In scenario B1, you are provided updated information on the same patient which was obtained during a re-screen one week later.
- Notice that each classification is a "point in time" process. Only current data are used to rate each indicator. As the data change, so does the patient's nutrition status classification.

### **INSTRUCTIONS FOR REVIEWING ALL EXAMPLE SCENARIOS:**

- A Nutrition Status Classification Worksheet is completed for each of the three example scenarios.
- Table 4, Normal Lab Values, on page 27, gives the lab values to be used for the example scenarios. **For the scenarios, assume that patients were admitted 48 hours ago, and that all diet orders and lab values are less than 48 hours old.**
- Review Table 5, "Nutrition Status Classification Scheme for Practice Scenarios" (page 29), to familiarize yourself with the relationship between the Nutrition Status Classification Scheme and Worksheet.
- Reference the "Summary of Ratings for Example Scenarios" (pages 43-47) for the rationale for rating each indicator.

After you have reviewed scenarios A, B and B1, STOP and discuss your questions and comments with your supervisor. Then proceed to page 49 to complete the practice scenarios.

**TABLE 4**  
**NORMAL LABORATORY VALUES**

TEST	NORMAL RANGE
Albumin	3.5 - 5.0 g/dL
Alkaline Phosphatase (A Phos)	50-125 u/L
Amylase	23-115 u/L
Blood Urea Nitrogen (BUN)	07-22 mg/dL
Calcium	9-10.6 mg/dL
Carbon Dioxide (CO <sub>2</sub> )	20-27 mEq/L
CD4	> 500 M/L
Chloride (Cl)	100-108 mEq/L
Cholesterol (Chol)	< 200 mg/dL
Creatinine	0.7-1.5 mg/dL
Gamma Glutamyl Transferase (GTP)	14-65 u/L
Glucose (Glu)	65-110 mg/dL
Hematocrit (Hct)	39-50 %
Hemoglobin (Hgb)	14-17 g/dL
Iron (Fe)	50-160 micrograms/dL
Magnesium (Mg)	1.8-2.4 mg/dL
Mean Corpuscular Volume (MCV)	82-98 fl
Potassium (K)	3.5-5.0 mEq/L
Protein, total	6-8 g/dL
Serum Phosphorus (PO <sub>4</sub> )	2.5-4.9 mg/dL
Sodium (Na)	135-145 mEq/L
Total Lymphocyte Count (TLC)	> 1,499 cells/cmm
Triglycerides (TG)	29-174 mg/dL
White Blood Count (WBC)	4.2-10.3 K/cmm



**TABLE 5**  
**NUTRITION STATUS CLASSIFICATION SCHEME FOR PRACTICE SCENARIOS**

INDICATORS	I NORMAL NUTRITION STATUS	II MILDLY COMPROMISED NUTRITION STATUS	III MODERATELY COMPROMISED NUTRITION STATUS	IV SEVERELY COMPROMISED NUTRITION STATUS
	①	②	③	④
<b>A.</b> Nutrition History	<ul style="list-style-type: none"> <li>- Appetite, good</li> <li>- Eating/digestion problems, none</li> <li>- Independent activities of daily living</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, fair</li> <li>- Chewing problems</li> <li>- Constipation</li> <li>- Limited activities of daily living</li> <li>- Nausea</li> <li>- Requires feeding assistance</li> <li>- Restricted ambulation</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, poor</li> <li>- Diarrhea</li> <li>- Swallowing problems</li> <li>- Vomiting</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, none</li> </ul>
<b>B.</b> Unintentional weight loss as % of usual body weight.	Stable Weight(no weight loss)	< 10 % - 6 mos.	10-15% in 6 mos. OR <7.5% in 3 mos. OR <5% in 1 mon. OR <2% in 1 wk.	>15% in 6 mos. OR > 7.5% in 3 mos. OR > 5% in 1 mon. OR > 2% in 1wk.
<b>C.</b> Weight as % of ideal body weight (IBW)	100 - 90% IBW <b>OR</b> < 119% IBW	89 - 81% IBW <b>OR</b> 120 - 129% IBW	80 - 75% IBW <b>OR</b> 130 - 149% IBW	< 74% IBW <b>OR</b> > 150% IBW
<b>D.</b> Diet	<ul style="list-style-type: none"> <li>- Mechanical</li> <li>- Regular</li> </ul>	<ul style="list-style-type: none"> <li>- ADA/Wt. Red.</li> <li>- Any consistency other than mechanical</li> <li>- Drug-Nutrient Interaction</li> <li>- Dysphagia</li> <li>- Lactose Free</li> <li>- Low Fat/Low Cholesterol</li> <li>- Sodium Restricted</li> </ul>	<ul style="list-style-type: none"> <li>- Fluid Restricted (&lt; 1000 cc)</li> <li>- Mineral Restricted other than Sodium</li> <li>- Protein Restricted</li> <li>- Tube feeding, stable</li> </ul>	<ul style="list-style-type: none"> <li>- Cl. Liq. &gt; 3 days</li> <li>- NPO &gt; 3 days</li> <li>- PPN</li> <li>- TPN</li> <li>- Tube feeding, unstable</li> </ul>
<b>E.</b> Diagnosis	<ul style="list-style-type: none"> <li>- All others including surgeries not mentioned</li> <li>- Dehydration</li> <li>- Electrolyte imbalance</li> <li>- F/U post surgery</li> <li>- HIV +</li> <li>- HTN</li> <li>- Psychological disorders</li> <li>- Total hip replacement</li> </ul>	<ul style="list-style-type: none"> <li>- Alcohol abuse</li> <li>- Alzheimer's disease</li> <li>- Amputation</li> <li>- Angina</li> <li>- Cancer (except GI tract, head &amp; neck)</li> <li>- Cardiac disease</li> <li>- COPD, stable</li> <li>- CVA</li> <li>- Dementia</li> <li>- Diabetes, controlled</li> <li>- Drug abuse</li> <li>- Fracture, other</li> <li>- GI disease, other</li> <li>- Neurological disorders, other</li> <li>- Nutritional anemia</li> <li>- Pneumonia</li> <li>- Pressure ulcer, stage I or II</li> <li>- Psychological eating disorder</li> <li>- PVD</li> <li>- Radiation therapy (except GI tract, head &amp; neck)</li> <li>- Renal disease</li> <li>- Substance abuse</li> <li>- Tuberculosis</li> </ul>	<ul style="list-style-type: none"> <li>- AIDS</li> <li>- Burns (&lt; 25% BSA)</li> <li>- Cancer involving GI tract or head &amp; neck</li> <li>- Cardiomyopathy</li> <li>- Chemotherapy</li> <li>- Congestive heart failure</li> <li>- COPD, unstable</li> <li>- CHF</li> <li>- Chronic renal failure</li> <li>- Diabetes, uncontrolled</li> <li>- Diabetes, new diagnosis</li> <li>- Dysphagia</li> <li>- Fracture, traumatic</li> <li>- GI disease w/ malabsorption or maldigestion</li> <li>- Hepatic disease</li> <li>- Infection w/fever</li> <li>- Neurological coma</li> <li>- Pressure ulcer, stage III</li> <li>- Pulmonary disease, O2 dependent</li> <li>- Radiation therapy for GI tract, head &amp; neck</li> <li>- SCI, new</li> <li>- Transplantation, major organ, stable</li> </ul>	<ul style="list-style-type: none"> <li>- Acute renal failure</li> <li>- Burns (&gt;25% BSA)</li> <li>- Cachexia</li> <li>- Failure to thrive</li> <li>- GI obstruction</li> <li>- Hepatic coma</li> <li>- Hepatic encephalopathy</li> <li>- Ileus</li> <li>- Malnutrition</li> <li>- Multiple trauma</li> <li>- Multi-system organ failure</li> <li>- Peritonitis</li> <li>- Pressure ulcer, stage IV</li> <li>- Pulmonary failure, ventilator dependent</li> <li>- Sepsis</li> <li>- Transplantation, major organ system, pre- and post-op</li> </ul>
<b>F.</b> Albumin (gm/dL)	> 3.5	3.0 - 3.4	2.5 - 2.9	< 2.4
<b>G.</b> TLC (cells/cmm)	> 1500	1499 - 1200	1199-800	< 799



**EXAMPLE SCENARIO A**  
**NUTRITION SCREENING**

Chewing Problems: Y  N  
 Dysphagia: Y  N  
 Appetite: + - fine  
 Feeding Assistance Required: Y  N  
 Constipation: Y  N  
 Food Allergies: none on file

Pre-Admission Diet: Regular  
 Wt + - \_\_\_# in last \_\_\_ months  
 Nausea: Y  N Vomiting: Y  N  
 Diarrhea: Y  N

Current Diet: 2 GM NA+, Low Fat  
 Adm. Dx: flutter/fibrillation  
 Age: 48 Sex: M  
 Height: 6' 1 1/2"  
 Weight: 164#  
 Usual Weight: 175-170#  
 Ideal Weight: 187#  
 Amputation %: 0

Prior Assessment:  
 Frame Size:  
 Weight Taken:  
 Weight/Usual Wt:  
 Weight/IBW:

Test	Laboratory Data		Units
	Result		
GLUCOSE	89		mg/dL
UREA NITROGEN	6		mg/dL
CREATININE	0.8		mg/dL
SODIUM	136		mEq/L
POTASSIUM	4.6		mEq/L
CHOLESTEROL	228		mg/dl
PROTEIN, TOTAL	8.2	H	g/dL
ALBUMIN	4.0		g/dL
HEMATOCRIT	34.4	L	%
MCV	74.2	L	fl
CALCIUM	8.7		mg/dL
PHOSPHATE	3.3		mg/dL
BILIRUBIN	0.6		mg/dL (normal is .3 - 1.5)
A. PHOSPHATASE	130	H	u/L
SGOT	40		IU/L (normal is 4 - 44)
WBC	6.9		K/cmm
HEMOGLOBIN	11.5	L	g/dL
TLC	1900		cells/cmm

Significant Medications: aluminum/magnesium HYD/simeth susp, 5 oz;  
 milk of magnesia 30 cc unit dose; acetaminophen 325 mg tablets UD;  
 digoxin 0.25 mg tab UD; and verapamil 80 mg tabs UD.



# Nutrition Status Classification Worksheet

## Example Scenario A

### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2)	Vomiting	(3)
Feeding assistance required	(2)	None of above	(1) <b>X</b>
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1. <b>1</b>
2. Please check ONE of the following describing the patient's appetite:			
Good	(1) <b>X</b>	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	
Poor	(3)		
Place the # corresponding to the rating you checked in BOX 2.			2. <b>1</b>
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			A. <b>1</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			A'.

### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	<b>173.5"</b>	Patient's current weight	<b>2. 164</b>	
Frame size (default = medium)	3. <b>M</b>	Ideal body weight (Calculate from ht./wt. tables)	4. <b>187</b>	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: $(2/4)*100=$			5. <b>88</b>	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			C. <b>2</b>	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			C'.	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true: - past weight data or time frame is missing or > 6 months old - patient has gained weight or weight is stable - wt. loss is due to diuresis, amputation or sensible dieting				
If not stated, assume wt. loss is unintentional.				
Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:				
Enter the previous weight and date.	Wt	<b>170-175</b>	1.	Date
		<b>?</b>	2.	
Enter the current weight and date.	Wt	<b>164</b>	3.	Date
		<b>Today</b>	4.	
Calculate the following: Weight Change: 1-3=		<b>6-9</b>	5.(Lbs or Kgs)	
Time Period: 2-4=		<b>?</b>	6.(Mos)	
If 5 > 0, calculate: % Weight Loss: $(5/1)*100=$		<b>?</b>	7.	%
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.				B. <b>—</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.				B'.
<b>Unintentional Weight Loss Ratings</b>				
	<b>Time Period</b>			
<b>Percent</b>	<b>&lt;2 Weeks</b>	<b>2 Weeks- &lt;2Months</b>	<b>2 Months- &lt;4 Months</b>	<b>4 Months- &lt;6 Months</b>
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

**Example Scenario A**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

D.	<b>2</b>	D'.	
----	----------	-----	--

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤ 3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO ≤ 3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

E.	<b>2</b>	E'.	
----	----------	-----	--

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Put the patient's most RECENT Albumin level (g/dl) in box 1.						<b>1.40</b>
Find the Albumin value in the table below and record the corresponding rating in BOX F.						
Alb.	No data OR > 6 Wks. old	>3.5	3.0- 3.4	2.5- 2.9	<2.4	
Rating	Leave Blank	1	2	3	4	
Place the actual Albumin RATING in BOX F.						<b>F. 1</b>
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'.						F'.

Place the patient's most RECENT TLC (cells/cmm) in BOX 1.						<b>11900</b>
Find the TLC value in the table below and record the corresponding rating in BOX G.						
TLC	No data OR > 6 Wks. old	>1500	1200- 1499	800- 1199	<799	
Rating	Leave Blank	1	2	3	4	
Place the actual RATING in BOX G.						<b>G. 1</b>
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'.						G'.

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

ACTUAL	A	B	C	D	E	F	G	Determine an overall rating for the patient using your clinical judgment and place here.	<b>OVERALL</b> <b>2</b>
ADJUSTED	A'	B'	C'	D'	E'	F'	G'		

**EXAMPLE SCENARIO B**  
(Initial Screening)

NUTRITION SCREENING

Chewing Problems: Y  N  
 Dysphagia: Y  N  
 Appetite: +  - poor  
 Feeding Assistance Required: Y  N  
 Constipation: Y  N  
 Food Allergies:

Pre-Admission Diet: **Regular**  
 Wt +  - 3.2 Kg. in last 3 months  
 Nausea:  Y  N Vomiting:  Y  N  
 Diarrhea: Y  N

Current Diet: NPO x 24 hrs.

Adm. Dx: Dehydration, R/O Ulcer disease

Age: 57 Sex: M

Height: 180 cm.

Weight: 64.1 Kg

Usual Weight: 67.3 Kg

Ideal Weight: 78.2 Kg

Amputation %:

Prior Assessment:

Frame Size: Medium

Weight Taken: 24 hrs. ago

Weight/Usual Wt:

Weight/IBW: 82%

Laboratory Data

Test	Result	Units
ALBUMIN	3.8	mg/dL
LYMPHOCYTES	1650	cells/cmm



## Nutrition Status Classification Worksheet Example Scenario B

### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2) <b>X</b>	Vomiting	(3) <b>X</b>
Feeding assistance required	(2)	None of above	(1)
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1. <b>3</b>
2. Please check ONE of the following describing the patient's appetite:			
Good	(1)	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	
Poor	(3) <b>X</b>		
Place the # corresponding to the rating you checked in BOX 2.			2. <b>3</b>
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			A. <b>3</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			A'.

### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	1. <b>180cm</b>	Patient's current weight	2. <b>64.1Kg</b>	
Frame size (default = medium)	3. <b>M</b>	Ideal body weight (Calculate from ht./wt. tables)	4. <b>78.2 Kg</b>	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: $(2/4)*100=$			5. <b>82</b>	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			C. <b>2</b>	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			C'.	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true: - past weight data or time frame is missing or > 6 months old - patient has gained weight or weight is stable - wt. loss is due to diuresis, amputation or sensible dieting				
If not stated, assume wt. loss is unintentional.				
Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:				
Enter the previous weight and date.	Wt	<b>67.3 Kg</b>	1.	
	Date	<b>3 mos ago</b>	2.	
Enter the current weight and date.	Wt	<b>64.1 Kg</b>	3.	
	Date	<b>Today</b>	4.	
Calculate the following:	<b>3.2 Kg</b> 5.(Lbs or Kgs)			
Weight Change: 1-3=	<b>3 mos</b> 6.(Mos)			
Time Period: 2-4=				
If 5 > 0, calculate:				
% Weight Loss: $(5/1)*100=$	<b>4.7</b>			% 7.
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.				B. <b>2</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.				B'.
<b>Unintentional Weight Loss Ratings</b>				
	<b>Time Period</b>			
<b>Percent</b>	<b>&lt;2 Weeks</b>	<b>2 Weeks- &lt;2Months</b>	<b>2 Months- &lt;4 Months</b>	<b>4 Months- &lt;6 Months</b>
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

**Example Scenario B**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

D.	D'.
---	

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤ 3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO ≤ 3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

E.	E'.
2	

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Put the patient's most RECENT Albumin level (g/dl) in box 1.					1. <b>3.8</b>
Find the Albumin value in the table below and record the corresponding rating in BOX F.					
	(g/dL)				
<b>Alb.</b>	No data OR > 6 Wks. old	>3.5	3.0-3.4	2.5-2.9	<2.4
<b>Rating</b>	Leave Blank	1	2	3	4
Place the actual Albumin RATING in BOX F.					F. <b>1</b>
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'.					F'.

Place the patient's most RECENT TLC (cells/cmm) in BOX 1.						1. <b>1650</b>
Find the TLC value in the table below and record the corresponding rating in BOX G.						
	(cells/cmm)					
<b>TLC</b>	No data OR > 6 Wks. old	>1500	1200-1499	800-1199	<799	
<b>Rating</b>	Leave Blank	1	2	3	4	
Place the actual RATING in BOX G.						G. <b>1</b>
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'.						G'.

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

ACTUAL	A <b>3</b>	B <b>2</b>	C <b>2</b>	D <b>---</b>	E <b>2</b>	F <b>1</b>	G <b>1</b>	Determine an overall rating for the patient using your clinical judgment and place here.
ADJUSTED	A'	B'	C'	D'	E'	F'	G'	

**OVERALL**  
2

**EXAMPLE SCENARIO B1**

After being NPO for 4 days, the dietitian charted recommendations. One week after admission, on rounds, it was announced that the test results revealed gastric cancer. This prompted the dietitian to rescreen the patient.

**NUTRITION SCREENING - Rescreen after one week**

Chewing Problems: Y  N  
 Dysphagia: Y  N  
 Appetite: + - npo  
 Feeding Assistance Required: Y  N  
 Constipation: Y  N  
 Food Allergies:

Pre-Admission Diet:  
 Wt +  1.8 Kg. in last months (1 week)  
 Nausea  N Vomiting:  N  
 Diarrhea: Y  N

Current Diet: NPO x 8 days  
 Adm. Dx: Gastric cancer  
 Age: 57 Sex: M  
 Height: 180 cm.  
 Weight: 62.3 Kg  
 Usual Weight: 67.3 Kg  
 Ideal Weight: 78.2 Kg  
 Amputation %:

Prior Assessment:  
 Frame Size: Medium  
 Weight Taken: 24 hrs. ago  
 Weight/Usual Wt:  
 Weight/IBW: 80%

**Laboratory Data**

Test	Result	Units
ALBUMIN	2.9	mg/dL
LYMPHOCYTES	1127	cells/cmm



## Nutrition Status Classification Worksheet

### Example Scenario B1

#### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2) <b>X</b>	Vomiting	(3) <b>X</b>
Feeding assistance required	(2)	None of above	(1)
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1. <b>3</b>
2. Please check ONE of the following describing the patient's appetite:			
Good	(1)	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	<b>X</b>
Poor	(3)		
Place the # corresponding to the rating you checked in BOX 2.			2. <u>        </u>
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			A. <b>3</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			A'. <u>        </u>

#### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	1 <b>180cm</b>	Patient's current weight	2 <b>62.3kg</b>	
Frame size (default = medium)	3. <b>M</b>	Ideal body weight (Calculate from ht./wt. tables)	4. <b>78.2Kg</b>	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: (2/4)*100=			5. <b>80</b>	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			C. <b>3</b>	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			C'. <u>        </u>	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

#### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true: - past weight data or time frame is missing or > 6 months old - patient has gained weight or weight is stable - wt. loss is due to diuresis, amputation or sensible dieting				
If not stated, assume wt. loss is unintentional.				
Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:				
Enter the previous weight and date.	Wt <b>64.1 Kg</b>	1.		
	Date <b>1 Wk. ago</b>	2.		
Enter the current weight and date.	Wt <b>62.3 Kg</b>	3.		
	Date <b>Today</b>	4.		
Calculate the following:			<b>1.8 Kg</b> 5.(Lbs or Kgs)	
Weight Change: 1-3=			<b>1 Week</b> 6.(Mos)	
Time Period: 2-4=				
If 5 > 0, calculate:			<b>2.8</b> % 7.	
% Weight Loss: (5/1)*100=				
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.			B. <b>4</b>	
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.			B'. <u>        </u>	
<b>Unintentional Weight Loss Ratings</b>				
	<b>Time Period</b>			
<b>Percent</b>	<b>&lt;2 Weeks</b>	<b>2 Weeks-&lt;2Months</b>	<b>2 Months-&lt;4 Months</b>	<b>4 Months-&lt;6 Months</b>
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

**Example Scenario**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

<b>D.</b>	<b>4</b>	<b>D'.</b>
-----------	----------	------------

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO < 3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

<b>E.</b>	<b>3</b>	<b>E'.</b>
-----------	----------	------------

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Put the patient's most RECENT Albumin level (g/dl) in box 1. **1. 2.9**

Find the Albumin value in the table below and record the corresponding rating in BOX F. (g/dL)

Alb.	No data OR > 6 Wks. old	>3.5	3.0-3.4	2.5-2.9	<2.4
<b>Rating</b>	Leave Blank	1	2	3	4

Place the actual Albumin RATING in BOX F. **F. 3**

If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'. **F'.**

Place the patient's most RECENT TLC (cells/cmm) in BOX 1. **11127**

Find the TLC value in the table below and record the corresponding rating in BOX G. (cells/cmm)

TLC	No data OR > 6 Wks. old	>1500	1200-1499	800-1199	<799
<b>Rating</b>	Leave Blank	1	2	3	4

Place the actual RATING in BOX G. **G. 3**

If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'. **G'.**

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

ACTUAL	A	B	C	D	E	F	G	Determine an overall rating for the patient using your clinical judgment and place here. <b>OVERALL 3</b>
	<b>3</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>3</b>	
ADJUSTED	A'	B'	C'	D'	E'	F'	G'	

## SUMMARY OF RATINGS FOR EXAMPLE SCENARIOS

### Example Scenario A

A. Nutrition History

No problems were noted. This factor is rated a I.

B. Unintentional Weight Loss

The patient has lost weight, but it is unclear as to the time period of the weight loss and whether it was an intentional loss. With incomplete information, this factor is not rated.

C. Percent of Ideal Body Weight

Ideal weight, assuming medium frame, is 187#.

$$\frac{164}{187} \times 100 = 88\% \text{ This percentage is rated a II.}$$

D. Diet

A low sodium, low fat diet is rated a II.

E. Diagnosis

A non-specific cardiac diagnosis is rated a II.

F. Albumin

Albumin is within normal limits and is rated a I.

G. Total Lymphocyte Count (TLC)

His TLC is > 1500 and is rated a I.

## Classification of Overall Nutrition Status

Patient "A" was classified as having an overall nutrition status of "mildly compromised" (Nutrition Status II) based upon the clinical judgment of the practitioner interpreting the specific indicators. The patient is not considered to be normal since there are a few nutrition related problems which impact the nutrition status.

### Nutrition Status Classification Formula

Ratings of the 7 indicators A-G, respectively, are: 1/missing/2/2/2/1/1  
 Top 3 ratings: 2/2/2  
 Sum of top 3 ratings: 2+2+2 = 6  
 Overall nutrition status from Table 3 (p. 22): II (mildly compromised)

### Example Scenario B - Initial Screening

#### A. Nutrition History

The patient had nausea and vomiting prior to admission. Presently the patient has a poor appetite. This factor is rated a III.

#### B. Unintentional Weight Loss

The patient's usual weight was 67.3 Kg. and he has lost 3.2 Kg. in the last 3 months. This is unintentional weight loss. The % loss is calculated as follows:

$$\frac{3.2}{67.3} \times 100 = 4.7\% \text{ in 3 months. This loss is rated a II.}$$

#### C. Percent of IBW

Since the patient has a medium frame, the formula is used as follows:

$$\frac{64.1}{78.2} \times 100 = 82\% \quad \text{This percentage is rated a II.}$$

D. Diet

Patient was admitted less than 24 hrs ago, and has been NPO since admission. NPO less than 3 days should NOT be given a rating.

E. Diagnosis

This patient is admitted with dehydration and rule out ulcer disease. Using the Classification Scheme, the best fit is GI Disease: All others. This is rated a II.

F. Albumin

The albumin is 3.8 g/dl. Using the laboratory reference range provided, this factor is rated a I.

G. TLC

The TLC was 1650 cells/cmm. Using the laboratory reference range provided, this factor is rated a I.

Classification of Overall Nutrition Status

Patient B was determined to be a Nutrition Status II, mildly compromised nutrition status. The rating for individual indicators are disparate. The clinician rated this patient a II, mildly compromised, realizing that as additional data become available the rating may change or remain the same. The patient may or may not begin eating and the diagnosis may or may not change.

Nutrition Status Classification Formula

Ratings of the 7 indicators are: 3/2/2/missing/2/1/1

Top 3 ratings: 3/2/2

Sum of top 3 ratings:  $3+2+2 = 7$

Overall nutrition status from Table 3 (p. 22): II, mildly compromised

**Example Scenario B1- One week Post Admission Rescreening**

## A. Nutrition History

There are no changes in the nutrition history. This indicator is rated a III.

## B. Unintentional Weight Loss

The patient has lost an additional 1.8 Kg. in the one week. Use his most recent weight for calculating his % weight loss, which is 64.1 (from the initial screening). The calculation is:

$$\frac{1.8}{64.1} \times 100 = 2.8\% \text{ in one week. This factor is rated a IV.}$$

## C. Percent IBW

With the additional weight loss, the percent ideal body weight is recalculated as:

$$\frac{62.3}{78.2} \times 100 = 80\% \text{ This percentage is rated a III.}$$

## D. Diet

This patient has now remained NPO for 8 days (despite dietitian charting feeding recommendations). This factor is rated a IV.

## E. Diagnosis

After workup, the diagnosis is confirmed as gastric cancer. This diagnosis is rated a III.

## F. Albumin

During the week, the admission diagnosis of dehydration has been resolved and repeat laboratory testing reveals a serum albumin of 2.9 gm/dl. Using the calculated albumin values for the provided reference range, this albumin is rated a III.

G. TLC

With additional laboratory testing, the patient's TLC is now 1127. Treatment for cancer which might affect TLC has not yet begun and therefore this factor is rated a III.

Classification of Overall Nutrition Status

Patient B1 was determined to be a Nutrition Status III, moderately compromised nutrition status. This patient was reclassified one week after admission. There were numerous changes in the medical condition. This patient has sub-optimal nutrition status and has significantly deteriorated in the past week.

Nutrition Status Classification Formula

Ratings of the 7 indicators are: 3/4/3/4/3/3/3

Top 3 ratings: 3/4/4

Sum of top 3 ratings:  $3+4+4 = 11$

Overall nutrition status from Table 3 (p. 22): III, moderately compromised



## 7.0 COMPLETING THE PRACTICE SCENARIOS

Practice Scenarios C, D and E are for you to complete.

- Complete the Nutrition Status Classification Worksheet for each scenario. Use Table 4, Normal Laboratory Values, page 27. Reference Table 5, "Nutrition Status Classification Scheme for Practice Scenarios," page 29.
- Compare your ratings for each indicator and for the overall status to those on pages 63-67.
- Discuss any questions with your supervisor.
- Your supervisor can obtain additional clarification by calling the individuals listed on the acknowledgment page.

**FOR THE FOLLOWING SCENARIOS, ASSUME THAT PATIENTS WERE ADMITTED 48 HOURS AGO AND THAT ALL DIET ORDERS AND LAB VALUES ARE LESS THAN 48 HOURS OLD.**



**PRACTICE SCENARIO C**

**NUTRITION SCREENING**

Chewing Problems:  Y  N toothache  
 Dysphagia: Y  N  
 Appetite: + - good  
 Feeding Assistance Required: Y  N  
 Constipation:  Y  N  
 Food Allergies: none on file

Pre-Admission Diet:  
 Wt + - 0 # in last months  
 Nausea:  Y  N Vomiting:  Y  N  
 Diarrhea:  Y  N

Current Diet: NPO  
 Adm. Dx: cataract OD  
 Age: 75 Sex: M  
 Height: 5' 10"  
 Weight: 206#  
 Usual Weight:  
 Ideal Weight: 166#  
 Amputation %: 0

Prior Assessment:  
 Frame Size:  
 Weight Taken:  
 Weight/Usual Wt:  
 Weight/IBW: 124%

Laboratory Data

Test	Result	Units
GLUCOSE	182 H	mg/dL
UREA NITROGEN	39. H	mg/dL
CREATININE	1.6 H	mg/dL
SODIUM	137	mEq/L
POTASSIUM	4.6	mEq/L
ALBUMIN	3.4 L	g/dL
HGB	13.3 L	g/dL
HEMATOCRIT	38.9 L	%

Medications: no current medications in selected drug classes.

Dietetic Encounters Last Three Years

26-Sep-91 PT CONTACT - NO NOTE, Individual  
 27-Sep-91 INSTRUCTION, RD INPT, Individual  
 RENAL EVALUATION INCLUDED  
 30-Sep-91 PT CONTACT- NO NOTE (FU), Individual

**PRACTICE SCENARIO C - (Cont.)**

1-Oct-91 PT CONTACT- NO NOTE (FU), Individual  
2-Oct-91 PT CONTACT- NO NOTE (FU), Individual  
27-Nov-91 RENAL ASSESSMENT, Individual  
29-Nov-91 PT CONTACT- NO NOTE (FU), Individual  
2-Dec-91 PT CONTACT- NO NOTE, Individual  
5-Dec-91 INSTRUCTION, RD INPT, Individual  
RENAL EVALUATION INCLUDED  
6-Dec-91 RENAL ASSESSMENT (FU), Individual  
9-Dec-91 PT CONTACT- NO NOTE, Individual  
10-Dec-91 PT CONTACT- NO NOTE, Individual  
11-Dec-91 PT CONTACT- NO NOTE (FU), Individual  
13-Dec-91 PT CONTACT- NO NOTE, Individual  
16-Dec-91 PT CONTACT- NO NOTE (FU), Individual  
7-Dec-91 PT CONTACT- NO NOTE, Individual  
19-Dec-91 RENAL ASSESSMENT (FU), Individual  
20-Dec-91 PT CONTACT- NO NOTE (FU), Individual  
23-Dec-91 PT CONTACT- NO NOTE, Individual  
31-Dec-91 PT CONTACT- NO NOTE (FU), Individual  
18-Jan-92 HIGH RISK ASSESSMENT, Individual  
13-Jan-92 COMMUNITY REFERRAL FORM, Individual  
13-Jan-92 HIGH RISK ASSESSMENT (FU), Individual  
15-Jan-92 RENAL ASSESSMENT, Individual  
4-Feb-92 INST-OUTPT: NG/PEG/TF, Individual

# Nutrition Status Classification Worksheet

## Practice Scenario C

### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2)	Vomiting	(3)
Feeding assistance required	(2)	None of above	(1)
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1.
2. Please check ONE of the following describing the patient's appetite:			
Good	(1)	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	
Poor	(3)		
Place the # corresponding to the rating you checked in BOX 2.			2.
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			<b>A.</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			<b>A'.</b>

### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	1.	Patient's current weight	2.	
Frame size (default = medium)	3.	Ideal body weight (Calculate from ht./wt. tables)	4.	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: $(2/4)*100=$			5.	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			<b>C.</b>	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			<b>C'.</b>	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true: - past weight data or time frame is missing or > 6 months old - patient has gained weight or weight is stable - wt. loss is due to diuresis, amputation or sensible dieting				
If not stated, assume wt. loss is unintentional.				
Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:				
Enter the previous weight and date.	Wt _____	1.	Date _____	2.
Enter the current weight and date.	Wt _____	3.	Date _____	4.
Calculate the following: Weight Change: $1-3=$	_____ 5. (Lbs or Kgs)			
Time Period: $2-4=$	_____ 6. (Mos)			
If $5 > 0$ , calculate: % Weight Loss: $(5/1)*100=$	_____ % 7.			
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.				<b>B.</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.				<b>B'.</b>
<b>Unintentional Weight Loss Ratings</b>				
	<b>Time Period</b>			
<b>Percent</b>	<b>&lt;2 Weeks</b>	<b>2 Weeks- &lt;2Months</b>	<b>2 Months- &lt;4 Months</b>	<b>4 Months- &lt;6 Months</b>
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

**Practice Scenario C**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

D.	D'.
----	-----

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤ 3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO ≤ 3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

E.	E'.
----	-----

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Put the patient's most RECENT Albumin level (g/dl) in box 1.					1.
Find the Albumin value in the table below and record the corresponding rating in BOX F.					
	No data OR > 6 Wks. old	>3.5	3.0-3.4	2.5-2.9	<2.4
<b>Rating</b>	Leave Blank	1	2	3	4
Place the actual Albumin RATING in BOX F.					F.
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'.					F'.

Place the patient's most RECENT TLC (cells/cmm) in BOX 1.						1.
Find the TLC value in the table below and record the corresponding rating in BOX G.						
	No data OR > 6 Wks. old	>1500	1200-1499	800-1199	<799	
<b>Rating</b>	Leave Blank	1	2	3	4	
Place the actual RATING in BOX G.						G.
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'.						G'.

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

ACTUAL	A	B	C	D	E	F	G	Determine an overall rating for the patient using your clinical judgment and place here.	<b>OVERALL</b>
ADJUSTED	A'	B'	C'	D'	E'	F'	G'		

**PRACTICE SCENARIO D**

**NUTRITION SCREENING**

Chewing Problems: Y N                      Pre-Admission Diet:  
 Dysphagia: Y N                              Wt + - # in last months  
 Appetite: + -                                  Nausea: Y N Vomiting: Y N  
 Feeding Assistance Required: Y N        Diarrhea: Y N  
 Constipation: Y N  
 Food Allergies:

Nutrition History: confused, not able to obtain

Current Diet: NPO  
 Adm. Dx: heme positive emesis, hepatic encephalopathy, ETOH abuse,  
           h/o upper gi bleeds, cirrhosis  
 Age: 58                                      Sex: M                                      Prior Assessment:  
 Height: 6' 0"                                      Frame Size:  
 Weight: 107.6 kg                                      Weight Taken: 24 hours ago  
 Usual Weight:                                      Weight/Usual Wt:  
 Ideal Weight: 81 kg                                      Weight/IBW:  
 Amputation %: 0

**Laboratory Data**

Test	Result	Units
GLUCOSE	79	mg/dL
UREA NITROGEN	15	mg/dL
CREATININE	1.0	mg/dL
SODIUM	128 L	mEq/L
POTASSIUM	3.1 L	mEq/L
ALBUMIN	2.8 L	g/dL
TLC	800 L	cells/cmm

BLOOD PRESSURE: 100/60

Significant Medications: lactulose



# Nutrition Status Classification Worksheet

## Practice Scenario D

### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2)	Vomiting	(3)
Feeding assistance required	(2)	None of above	(1)
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1.
2. Please check ONE of the following describing the patient's appetite:			
Good	(1)	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	
Poor	(3)		
Place the # corresponding to the rating you checked in BOX 2.			2.
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			A.
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			A'.

### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	1.	Patient's current weight	2.	
Frame size (default = medium)	3.	Ideal body weight (Calculate from ht./wt. tables)	4.	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: $(2/4)*100=$			5.	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			C.	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			C'.	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true:

- past weight data or time frame is missing or > 6 months old
- patient has gained weight or weight is stable
- wt. loss is due to diuresis, amputation or sensible dieting

If not stated, assume wt. loss is unintentional.

Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:

Enter the previous weight and date.	Wt _____ 1.
	Date _____ 2.
Enter the current weight and date.	Wt _____ 3.
	Date _____ 4.
Calculate the following:	
Weight Change: 1-3=	_____ 5.(Lbs or Kgs)
Time Period: 2-4=	_____ 6.(Mos)
If 5 >0, calculate:	
% Weight Loss: $(5/1)*100=$	_____ % 7.

Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.

	B.
--	----

You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.

	B'.
--	-----

### Unintentional Weight Loss Ratings

Percent	Time Period			
	<2 Weeks	2 Weeks-<2Months	2 Months-<4 Months	4 Months-<6 Months
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

**Practice Scenario D**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

D.	D'.
----	-----

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO ≤3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

E.	E'.
----	-----

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Put the patient's most RECENT Albumin level (g/dl) in box 1.

1.
----

Find the Albumin value in the table below and record the corresponding rating in BOX F.

Alb.	No data OR > 6 Wks. old	>3.5	3.0-3.4	2.5-2.9	<2.4
<b>Rating</b>	Leave Blank	1	2	3	4

Place the actual Albumin RATING in BOX F.

F.
----

If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'.

F'.
-----

Place the patient's most RECENT TLC (cells/cmm) in BOX 1.

1.
----

Find the TLC value in the table below and record the corresponding rating in BOX G.

TLC	No data OR > 6 Wks. old	>1500	1200-1499	800-1199	<799
<b>Rating</b>	Leave Blank	1	2	3	4

Place the actual RATING in BOX G.

G.
----

If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'.

G'.
-----

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

ACTUAL	A	B	C	D	E	F	G	Determine an overall rating for the patient using your clinical judgment and place here.	<b>OVERALL</b>
ADJUSTED	A'	B'	C'	D'	E'	F'	G'		

**PRACTICE SCENARIO E**

**NUTRITION SCREENING**

Chewing Problems: Y  N  
 Dysphagia: Y  N  
 Appetite: + - good  
 Feeding Assistance Required: Y  N  
 Constipation: Y  N  
 Food Allergies: none

Pre-Admission Diet: Regular  
 Wt. +  - 10# in last 2 months  
 Nausea: Y  N Vomiting: Y  N  
 Diarrhea: Y  N

Current Diet: clear liquid  
 Adm. Dx: prostate CA, HTN  
 Age: 64 Sex: M  
 Height: 5' 10"  
 Weight: 205#  
 Usual Weight:  
 Ideal Weight: 166#  
 Amputation %:

Prior Assessment:  
 Frame Size:  
 Weight Taken:  
 Weight/Usual Wt:  
 Weight/IBW: 123%

Weight History: patient trying to lose weight

Laboratory Data

Test	Result	Units
GLUCOSE	103	mg/dL
UREA NITROGEN	10.	mg/dL
CREATININE	.7	mg/dL
SODIUM	142.	mEq/L
POTASSIUM	3.9	mEq/L
ALBUMIN	4.4	g/dL
HGB	14.3	g/dL
HEMATOCRIT	42.8	%
TLC	1500	cells/cmm

Medications: no current medications in selected drug classes.



## Nutrition Status Classification Worksheet Practice Scenario E

### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2)	Vomiting	(3)
Feeding assistance required	(2)	None of above	(1)
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1.
2. Please check ONE of the following describing the patient's appetite:			
Good	(1)	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	
Poor	(3)		
Place the # corresponding to the rating you checked in BOX 2.			2.
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			<b>A.</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			<b>A'.</b>

### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	1.	Patient's current weight	2.	
Frame size (default = medium)	3.	Ideal body weight (Calculate from ht./wt. tables)	4.	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: $(2/4)*100=$			5.	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			<b>C.</b>	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			<b>C'.</b>	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true:	
<ul style="list-style-type: none"> <li>- past weight data or time frame is missing or &gt; 6 months old</li> <li>- patient has gained weight or weight is stable</li> <li>- wt. loss is due to diuresis, amputation or sensible dieting</li> </ul>	
If not stated, assume wt. loss is unintentional.	
Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:	
Enter the previous weight and date.	Wt _____ 1. Date _____ 2.
Enter the current weight and date.	Wt _____ 3. Date _____ 4.
Calculate the following: Weight Change: 1-3=	_____ 5.(Lbs or Kgs)
Time Period: 2-4=	_____ 6.(Mos)
If 5 >0, calculate: % Weight Loss: $(5/1)*100=$	_____ % 7.
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.	<b>B.</b>
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.	<b>B'.</b>

### Unintentional Weight Loss Ratings

Percent	Time Period			
	<2 Weeks	2 Weeks- <2Months	2 Months- <4 Months	4 Months- <6 Months
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

**Practice Scenario E**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

D.	D'.
----	-----

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤ 3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO ≤ 3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

E.	E'.
----	-----

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Put the patient's most RECENT Albumin level (g/dl) in box 1.					1.
Find the Albumin value in the table below and record the corresponding rating in BOX F.					
<b>Alb.</b>	No data OR > 6 Wks. old	>3.5	3.0-3.4	2.5-2.9	<2.4
<b>Rating</b>	Leave Blank	1	2	3	4
Place the actual Albumin RATING in BOX F.					F.
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'.					F'.

Place the patient's most RECENT TLC (cells/cmm) in BOX 1.						1.
Find the TLC value in the table below and record the corresponding rating in BOX G.						
<b>TLC</b>	No data OR > 6 Wks. old	>1500	1200-1499	800-1199	<799	
<b>Rating</b>	Leave Blank	1	2	3	4	
Place the actual RATING in BOX G.						G.
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'.						G'.

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

<b>ACTUAL</b>	A	B	C	D	E	F	G	Determine an overall rating for the patient using your clinical judgment and place here.	<b>OVERALL</b>
<b>ADJUSTED</b>	A'	B'	C'	D'	E'	F'	G'		

## ANSWERS TO PRACTICE SCENARIOS C, D AND E

### Practice Scenario C

A. Nutrition History

The patient had nausea and vomiting, along with problems of diarrhea and constipation. Appetite is good. The most compromised indicators are vomiting and diarrhea and this indicator is therefore rated a III.

B. Unintentional Weight Loss

This indicator is not rated because there is no weight history.

C. Percent of Ideal Body Weight

The patient is 124% of ideal body weight. This percentage results in a rating of II.

D. Diet

The current diet order is NPO and as stated in the instructions, the patient has been admitted for 48 hours. An NPO of less than 3 days is not rated, therefore this indicator should be left blank.

E. Diagnosis

The admission diagnosis would be classified as "Surgeries: all not mentioned". This gives the indicator a rating of I.

F. Albumin

The albumin is 3.4 g/dl. Using the range provided, this indicator is rated a II.

G. TLC

The TLC is not available. This indicator is not rated.

## Classification of Overall Nutrition Status

The patient has slight deterioration in his nutrition status. The patient has a few nutrition related problems which impact nutrition status. This patient is considered somewhat nutritionally stable. The overall nutrition status is rated a II, mildly compromised.

Addendum: The information in Dietetic Encounters SHOULD NOT be considered in determining the current nutrition status. There is no indication that the patient currently has a tube feeding or renal problems. If those data were available, or if they become available, then they should be considered in rating either an individual indicator or the overall nutrition status.

### Nutrition Status Classification Formula

Ratings of the 7 indicators are: 3/missing/2/missing/1/2/missing  
 Top 3 ratings: 3/2/2  
 Sum of top 3 ratings: 3+2+2 = 7  
 Overall nutrition status, from Table 3 (p. 22): II, mildly compromised

## Practice Scenario D

### A. Nutrition History

Data were not obtainable because the patient is confused. Therefore, this indicator is not rated.

### B. Unintentional Weight Loss

This indicator is not rated because there is no weight history.

### C. Percent Ideal Body Weight

This patient is determined to be 133% of his ideal body weight.

$$\frac{107.6 \text{ Kg}}{81.0 \text{ Kg}} \times 100 = 133\%$$

This indicator is rated a III.

D. Diet

This patient's diet order is NPO. As defined in the instructions, the time frame is less than 48 hours. Therefore, this indicator is not rated.

E. Diagnosis

This patient is admitted with several diagnoses. Hepatic encephalopathy is rated a IV, so this indicator is rated a IV.

F. Albumin

The albumin is 2.8 g/dl. Using the laboratory reference range provided, this indicator is rated a III.

G. TLC

The patient's TLC is 800. This value is rated a III.

Classification of Overall Nutrition Status

This patient has significant deterioration in nutrition status. This patient is considered to be nutritionally unstable and is rated a III.

Addendum: To classify the overall nutrition status, a minimum of 4 indicators need to be available.

Nutrition Status Classification Formula

Ratings of the 7 indicators are: missing/missing/3/missing/4/3/3

Top 3 ratings are: 4/3/3

Sum of top 3 ratings:  $4+3+3 = 10$

Overall nutrition status from Table 3 (p. 22): III, moderately compromised

## Practice Scenario E

### A. Nutrition History

All factors in the nutrition history are rated normal. Therefore, this indicator is rated a I.

### B. Unintentional Weight Loss

The patient indicates that he has been trying to lose weight. For this reason the indicator is not rated.

### C. Percent Ideal Body Weight

The weight/IBW is already determined at 123%. This percentage is rated a II.

### D. Diet

The current diet order is clear liquid, and is less than 3 days (instructions state time frame is less than 48 hours). Therefore, this indicator is not rated.

### E. Diagnosis

The patient is admitted with prostate cancer and hypertension. Prostate cancer would be classified as "Cancer: All others" and rated a II. Hypertension is rated a I. Using the highest (or most compromised) rating, this indicator is rated a II.

### F. Albumin

The albumin is 4.4 g/dl. Based upon the laboratory reference ranges provided, this indicator is rated a I.

### G. TLC

The TLC is 1500. This value is rated a I.

## Classification of Overall Nutrition Status

This patient is considered nutritionally stable. The patient's weight loss was intentional. Those indicators rated as mildly compromised do not impact nutrition status. This patient is rated a I, normal nutrition status.

## Nutrition Status Classification Formula

Ratings of the 7 indicators are: 1/missing/2/missing/2/1/1

Top 3 ratings: 2/2/1

Sum of top 3 ratings:  $2+2+1 = 5$

Overall nutrition status from Table 3 (p. 22): I, normal nutrition status



## **APPENDICES**



## APPENDIX A NUTRITION STATUS CLASSIFICATION SCHEME REFERENCES

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**APPENDIX B  
SAMPLE CALCULATIONS FOR DETERMINING UNINTENTIONAL  
WEIGHT LOSS**

Formula, with examples, for calculations of weight loss as percent of usual body weight:

Basic Formula: 
$$\frac{\text{usual weight} - \text{current weight}}{\text{usual weight}} \times 100 = \text{percent weight loss}$$

Example 1: Usual weight = 79.5 kgs      Time frame = 5 months  
Current weight = 64.5 kgs

$$\frac{79.5 \text{ kg} - 64.5 \text{ kg}}{79.5 \text{ kg}} \times 100 = \frac{15 \text{ kg}}{79.5 \text{ kg}} \times 100 = 19\%$$

This weight loss would be rated severely compromised, IV

Example 2: Usual Weight = 155 #      Time frame = 3 months  
Current Weight = 145#

$$\frac{155\# - 145\#}{155\#} \times 100 = 6.5\%$$

This weight loss would be rated moderately compromised, III

Example 3: Usual Weight = 70.5 kg      Time frame = 5 months  
Current Weight = 64.0 kg

$$\frac{70.5 \text{ kg} - 64 \text{ kg}}{70.5 \text{ kg}} \times 100 = 9.2 \%$$

This weight loss would be rated mildly compromised, II

Note: Table 1, "Nutrition Status Classification Scheme," does not clearly classify 9.2% weight loss within 5 months. The Nutrition Status Classification Worksheet provides a precise classification.

Example 4: Usual Weight = 155#      Time frame = 6 months  
Current Weight = 128#

$$\frac{155\# - 128\#}{155\#} \times 100 = 17.4\%$$

This weight loss would be rated severely compromised, IV

**APPENDIX C  
SAMPLE CALCULATIONS FOR DETERMINING PERCENT OF IDEAL  
BODY WEIGHT**

Formula with examples for calculating percent of ideal body weight (Hamwi Method):

Basic Formula: 
$$\frac{\text{Current weight}}{\text{Ideal weight}} \times 100 = \% \text{ Ideal Body Weight}$$

Adjusted for Large Frame: 
$$\frac{\text{Current weight}}{[(\text{ideal weight})(10\%)] + \text{ideal weight}} \times 100 = \% \text{ IBW}$$

Example 1. A male, of medium frame, weighs 140# and is 5'10" tall. His ideal body weight is estimated at 166#.

$$\frac{140\#}{166\#} \times 100 = 84\% \text{ Ideal Body Weight}$$

This is rated mildly compromised, II

Example 2. A male, of large frame, weighs 95.5 Kg. and is 182 cm. tall. Unadjusted ideal body weight using the Hamwi formula is 80.9.

$$\frac{95.5}{[(80.9)(0.10)] + 80.9} \times 100$$

$$\frac{95.5}{8.09 + 80.9} \times 100 = \frac{95.5}{88.99} \times 100 = 107\%$$

This is rated normal nutrition status, I



## APPENDIX D NUTRITION STATUS RATINGS FOR SELECTED DIAGNOSES

Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Liver disease
(2)	Alcohol abuse	(4)	Malnutrition
(2)	Alzheimer's disease	(4)	Multiple trauma
(2)	Amputation	(4)	Multi-system organ failure
(2)	Angina	(3)	Neurological disorders: coma
(2)	Atherosclerosis	(2)	Neurological disorders: others
(3)	Burns (<25%BSA)	(2)	Nutritional anemia
(4)	Burns (>25%BSA)	(2)	Osteomyelitis
(4)	Cachexia	(2)	Peripheral vascular disease
	CANCER:	(4)	Peritonitis
(3)	- Head & neck	(2)	Pneumonia
(3)	- GI tract	(2)	Prostate cancer
(2)	- All others		PSYCH. DISORDERS:
(2)	Cardiac disease	(2)	- Eating disorders
(3)	Cardiomyopathy	(1)	- Others
(3)	Chemotherapy		PULMONARY DISEASE:
(3)	Congestive heart failure	(2)	- COPD, stable
(2)	CVA	(3)	- COPD, unstable
	Decubitis ulcers (see pressure ulcers)	(3)	- O2 dependent
(1)	Dehydration	(4)	- Failure requiring vent
(2)	Dementia		PRESSURE ULCERS:
(2)	Diabetes: controlled	(2)	- Stage I & II
(3)	Diabetes: uncontrolled	(3)	- Stage III
(3)	Diabetes: newly diagnosed	(4)	- Stage IV
(2)	Drug abuse		RADIATION THERAPY:
(3)	Dysphagia	(3)	- Head & neck
(1)	Electrolyte imbalance	(3)	- GI tract
(2)	Endocrine, not diabetes	(2)	- All others
(3)	Esophageal stricture	(2)	Renal disease
(4)	Failure to thrive	(4)	Renal failure, acute
(3)	Fracture, traumatic	(3)	Renal failure, chronic
(2)	Fracture, other	(4)	Respiratory failure
	GI DISEASE:	(1)	Schizophrenia
(3)	- W/ malabsorp. or maldigest.	(4)	Sepsis
(2)	- All others	(3)	Spinal cord injury (SCI), new
(4)	GI obstruction	(2)	Substance abuse
(3)	Head trauma		SURGERIES:
(4)	Hepatic coma	(1)	- Post-Op follow up
(4)	Hepatic encephalopathy	(4)	- Transplant, major organ
(1)	HIV+	(1)	- All others
(2)	Hospice/comfort care	(1)	Total hip replacement
(1)	Hypertension (HTN)		TRANSPLANT:
(4)	Ileus	(4)	- Major organ system, pre- and post-op
(3)	Infection w/ fever	(3)	- Stable
		(2)	Tuberculosis



## APPENDIX E CALCULATION OF ALBUMIN LEVELS

To convert the standard deviation (SD) ranges on Table 1 to the actual albumin levels for your facility, the following calculations need to be completed. From your laboratory service, obtain the standard deviation of the albumin test used. It is recommended that you utilize the data for a normal or test population and not for the patient population. After determining the calculated ranges for your facility, add the values to the Nutrition Status Classification Scheme (Appendix F) and also to the Nutrition Status Classification Worksheet (Appendix G).

Sample calculation for a hospital using:

- \* mean albumin level of 4.3 g/dl
- \* normal range of 3.8 to 4.8 g/dl
- \* standard deviation of 0.25

Nutrition Status I represents > minus 2 SD from the mean:

$$\begin{aligned}
 &= [(-2)(SD)] + \text{mean albumin level (g/dl)} \\
 &= [(-2)(0.25)] + 4.3 \text{ g/dl} \\
 &= -0.5 + 4.3 \text{ g/dl} \\
 &= 3.8 \text{ g/dl}
 \end{aligned}$$

For Normal Nutrition Status I, this hospital would use > 3.8 g/dl.

Nutrition Status II represents minus 2.3 to minus 3.3 SD from the mean:

$  \begin{aligned}  &= [(-2.3)(SD)] + \text{mean alb.} \\  &= [(-2.3)(0.25)] + 4.3 \text{ g/dl} \\  &= -0.575 + 4.3 \text{ g/dl} \\  &= 3.725 \text{ g/dl}  \end{aligned}  $	to	$  \begin{aligned}  &= [(-3.3)(SD)] + \text{mean alb.} \\  &= [(-3.3)(-0.25)] + 4.3 \text{ g/dl} \\  &= -0.825 + 4.3 \text{ g/dl} \\  &= 3.475 \text{ g/dl}  \end{aligned}  $
Rounding to	to	3.5 g/dl
3.7 g/dl		

For Nutrition Status II, this hospital would use 3.7 g/dl to 3.5 g/dl.

Nutrition Status III represents minus 3.6 to minus 4.6 SD from the mean:

$$\begin{aligned}
 &= [(-3.6)(SD)] + \text{mean alb.} & \text{to} &= [(-4.6)(SD)] + \text{mean alb.} \\
 &= [(-3.6)(0.25)] + 4.3 \text{ g/dl} & \text{to} &= [(-4.6)(0.25)] + 4.3 \text{ g/dl} \\
 &= -0.9 + 4.3 \text{ g/dl} & \text{to} &= -1.15 + 4.3 \text{ g/dl} \\
 &= 3.4 \text{ g/dl} & \text{to} &= 3.15 \text{ g/dl} \\
 \\ 
 &\text{Rounding to} & & \text{to} \\
 &3.4 \text{ g/dl} & & 3.2 \text{ g/dl}
 \end{aligned}$$

For Nutrition Status III, this hospital would use 3.4 g/dl to 3.2 g/dl.

Nutrition Status IV represents < minus 4.9 SD from the mean:

$$\begin{aligned}
 &= [(-4.9)(SD)] + \text{mean albumin} \\
 &= [(-4.9)(0.25)] + 4.3 \text{ g/dl} \\
 &= -1.225 + 4.3 \text{ g/dl} \\
 &= 3.075 \text{ g/dl} \\
 \\ 
 &\text{Rounding to} & & 3.1 \text{ g/dl}
 \end{aligned}$$

For Nutrition Status IV, this hospital would use < 3.1 g/dl

If your hospital cannot provide the mean and standard deviation albumin level, you may determine the albumin levels using only the normal range for your hospital by completing the following calculations.

Normal Range of 3.8 to 4.8 g/dl

$$\text{Estimated Mean: } \frac{3.8 + 4.8}{2} = \frac{8.6}{2} = 4.3 \text{ g/dl}$$

Estimated Standard Deviation:  $\frac{\text{Upper Limit of Normal Range} - \text{Mean Albumin}}{2}$

$$\text{Estimated SD} = \frac{4.8 - 4.3}{2} = \frac{0.50}{2} = 0.25$$

**APPENDIX F**  
**NUTRITION STATUS CLASSIFICATION SCHEME**

INDICATORS	I NORMAL NUTRITION STATUS  ①	II MILDLY COMPROMISED NUTRITION STATUS  ②	III MODERATELY COMPROMISED NUTRITION STATUS  ③	IV SEVERELY COMPROMISED NUTRITION STATUS  ④
<b>A.</b> Nutrition History	<ul style="list-style-type: none"> <li>- Appetite, good</li> <li>- Eating/digestion problems, none</li> <li>- Independent activities of daily living</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, fair</li> <li>- Chewing problems</li> <li>- Constipation</li> <li>- Limited activities of daily living</li> <li>- Nausea</li> <li>- Requires feeding assistance</li> <li>- Restricted ambulation</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, poor</li> <li>- Diarrhea</li> <li>- Swallowing problems</li> <li>- Vomiting</li> </ul>	<ul style="list-style-type: none"> <li>- Appetite, none</li> </ul>
<b>B.</b> Unintentional weight loss as % of usual body weight.	Stable Weight(no weight loss)	< 10 % - 6 mos.	10-15% in 6 mos. OR <7.5% in 3 mos. OR <5% in 1 mon. OR <2% in 1 wk.	>15% in 6 mos. OR > 7.5% in 3 mos. OR > 5% in 1 mon. OR > 2% in 1 wk.
<b>C.</b> Weight as % of ideal body weight (IBW)	100 - 90% IBW <b>OR</b> < 119% IBW	89 - 81% IBW <b>OR</b> 120 - 129% IBW	80 - 75% IBW <b>OR</b> 130 - 149% IBW	< 74% IBW <b>OR</b> > 150% IBW
<b>D.</b> Diet	<ul style="list-style-type: none"> <li>- Mechanical</li> <li>- Regular</li> </ul>	<ul style="list-style-type: none"> <li>- ADA/Wt. Red.</li> <li>- Any consistency other than mechanical</li> <li>- Drug-Nutrient Interaction</li> <li>- Dysphagia</li> <li>- Lactose Free</li> <li>- Low Fat/Low Cholesterol</li> <li>- Sodium Restricted</li> </ul>	<ul style="list-style-type: none"> <li>- Fluid Restricted (&lt; 1000 cc)</li> <li>- Mineral Restricted other than Sodium</li> <li>- Protein Restricted</li> <li>- Tube feeding, stable</li> </ul>	<ul style="list-style-type: none"> <li>- Cl. Liq. &gt; 3 days</li> <li>- NPO &gt; 3 days</li> <li>- PPN</li> <li>- TPN</li> <li>- Tube feeding, unstable</li> </ul>
<b>E.</b> Diagnosis	<ul style="list-style-type: none"> <li>- All others including surgeries not mentioned</li> <li>- Dehydration</li> <li>- Electrolyte imbalance</li> <li>- F/U post surgery</li> <li>- HIV +</li> <li>- HTN</li> <li>- Psychological disorders</li> <li>- Total hip replacement</li> </ul>	<ul style="list-style-type: none"> <li>- Alcohol abuse</li> <li>- Alzheimer's disease</li> <li>- Amputation</li> <li>- Angina</li> <li>- Cancer (except GI tract, head &amp; neck)</li> <li>- Cardiac disease</li> <li>- COPD, stable</li> <li>- CVA</li> <li>- Dementia</li> <li>- Diabetes, controlled</li> <li>- Drug abuse</li> <li>- Fracture, other</li> <li>- GI disease, other</li> <li>- Neurological disorders, other</li> <li>- Nutritional anemia</li> <li>- Pneumonia</li> <li>- Pressure ulcer, stage I or II</li> <li>- Psychological eating disorder</li> <li>- PVD</li> <li>- Radiation therapy (except GI tract, head &amp; neck)</li> <li>- Renal disease</li> <li>- Substance abuse</li> <li>- Tuberculosis</li> </ul>	<ul style="list-style-type: none"> <li>- AIDS</li> <li>- Burns (&lt;25% BSA)</li> <li>- Cancer involving GI tract or head &amp; neck</li> <li>- Cardiomyopathy</li> <li>- Chemotherapy</li> <li>- Congestive heart failure</li> <li>- COPD, unstable</li> <li>- CHF</li> <li>- Chronic renal failure</li> <li>- Diabetes, uncontrolled</li> <li>- Diabetes, new diagnosis</li> <li>- Dysphagia</li> <li>- Fracture, traumatic</li> <li>- GI disease w/ malabsorption or maldigestion</li> <li>- Hepatic disease</li> <li>- Infection w/fever</li> <li>- Neurological coma</li> <li>- Pressure ulcer, stage III</li> <li>- Pulmonary disease, 02 dependent</li> <li>- Radiation therapy for GI tract, head &amp; neck</li> <li>- SCI, new</li> <li>- Transplantation, major organ, stable</li> </ul>	<ul style="list-style-type: none"> <li>- Acute renal failure</li> <li>- Burns (&gt;25% BSA)</li> <li>- Cachexia</li> <li>- Failure to thrive</li> <li>- GI obstruction</li> <li>- Hepatic coma</li> <li>- Hepatic encephalopathy</li> <li>- Ileus</li> <li>- Malnutrition</li> <li>- Multiple trauma</li> <li>- Multi-system organ failure</li> <li>- Peritonitis</li> <li>- Pressure ulcer, stage IV</li> <li>- Pulmonary failure, ventilator dependent</li> <li>- Sepsis</li> <li>- Transplantation, major organ system, pre- and post-op</li> </ul>
<b>F.</b> Albumin (gm/dL) S.D. = Standard Deviations				
<b>G.</b> TLC (cells/cmm)	> 1500	1499 - 1200	1199-800	< 799



## APPENDIX G

### Nutrition Status Classification Worksheet

#### SECTION A. NUTRITION HISTORY

1. Please check ALL that apply. (The #'s correspond to Nutrition History rating categories)			
Chewing problems	(2)	Diarrhea	(3)
Constipation	(2)	Swallowing problems	(3)
Nausea	(2)	Vomiting	(3)
Feeding assistance required	(2)	None of above	(1)
Limited Activities of Daily Life	(2)	Info. on pt. not available (Leave Box 1 Blank)	
Restricted ambulation	(2)		
Looking at the boxes you checked, place the highest corresponding value in BOX 1			1.
2. Please check ONE of the following describing the patient's appetite:			
Good	(1)	None	(4)
Fair	(2)	Info. not available (Leave Box 2 Blank)	
Poor	(3)		
Place the # corresponding to the rating you checked in BOX 2.			2.
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the ACTUAL nutrition history rating.			A.
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX A'.			A'.

#### SECTION C. % IDEAL BODY WEIGHT

Patient's Height	1.	Patient's current weight	2.	
Frame size (default = medium)	3.	Ideal body weight (Calculate from ht./wt. tables)	4.	
If the patient's height or weight is MISSING, STOP and Leave BOX C BLANK.				
Calculate % of ideal body weight: $(2/4)*100=$			5.	
Using the value in box 5, find the patient's ACTUAL % of body weight rating in the table below. Place this rating in BOX C.			C.	
If you wish you may adjust the rating based on other pt. information. Place the ADJUSTED rating in BOX C'.			C'.	
<b>% Ideal Body Weight Scores</b>				
Value From Box 5 Above	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or > 150
Rating	1	2	3	4

#### SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true:				
<ul style="list-style-type: none"> <li>- past weight data or time frame is missing or &gt; 6 months old</li> <li>- patient has gained weight or weight is stable</li> <li>- wt. loss is due to diuresis, amputation or sensible dieting</li> </ul>				
If not stated, assume wt. loss is unintentional.				
Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:				
Enter the previous weight and date.	Wt _____	1.	Date _____	2.
Enter the current weight and date.	Wt _____	3.	Date _____	4.
Calculate the following:	_____ 5. (Lbs or Kgs)			
Weight Change: 1-3=	_____ 6. (Mos)			
Time Period: 2-4=	_____ % 7.			
If 5 > 0, calculate:				
% Weight Loss: $(5/1)*100=$				
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.				B.
You may wish to adjust the rating based on other pt. information. If so, place the ADJUSTED rating in BOX B'.				B'.
<b>Unintentional Weight Loss Ratings</b>				
	<b>Time Period</b>			
<b>Percent</b>	<b>&lt;2 Weeks</b>	<b>2 Weeks- &lt;2Months</b>	<b>2 Months- &lt;4 Months</b>	<b>4 Months- &lt;6 Months</b>
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

**SECTION D. DIET**

Circle the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If the patient's diet is "DEFAULT" or there is NO ORDER, STOP here and leave BOX D BLANK. If you wish to adjust the rating based on other pt. info, place the ADJUSTED score in BOX D'.

D.	D'.
----	-----

Rating	Diet Name	Rating	Diet Name	Rating	Diet Name
(2)	ADA/Wt. reduction	(3)	Fluid restriction (<1000cc)	(4)	PPN
(4)	Clear liquids > 3 Days	(2)	Lactose free	(3)	Protein restricted
Blank	Clear liquids ≤3 days	(2)	Low fat/Low cholesterol	(1)	Regular
(2)	Consistency other than mechanical	(1)	Mechanical	(2)	Sodium restricted
(2)	Drug-nutrient interaction	(3)	Mineral restricted other than sodium	(4)	TPN
(2)	Dysphagia	Blank	NPO ≤3 days	(3)	Tube feeding, Stable
		(4)	NPO > 3 days	(4)	Tube feeding, unstable
					Other (specify) _____

**SECTION E. DIAGNOSIS**

Circle ALL of the patient's diagnoses in the table below. Find the diagnosis with the HIGHEST corresponding rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so please refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement. Place any ADJUSTED rating in BOX E'.

E.	E'.
----	-----

Rating	Diagnosis	Rating	Diagnosis	Rating	Diagnosis
(3)	AIDS	(3)	Fracture, traumatic		Psychological disorders:
(2)	Alzheimer's disease	(2)	Fracture, other	(2)	Eating disorders
(2)	Angina		GI disease:	(1)	Others
	Cancer:	(3)	W/ malabsorp. or maldigest.		Pulmonary disease:
(3)	Head & neck	(2)	All others	(3)	O2 dependent
(3)	GI tract	(4)	GI obstruction	(4)	Failure requiring vent
(2)	All others	(4)	Hepatic coma	(2)	Peripheral vascular disease
(2)	Cardiac disease	(4)	Hepatic encephalopathy		Radiation therapy:
(3)	Cardiomyopathy	(1)	HIV+	(3)	Head & neck
(3)	Chemotherapy	(1)	Hypertension (HTN)	(3)	GI tract
(3)	Congestive heart failure	(4)	Ileus	(2)	All others
(2)	COPD, stable	(3)	Infection w/ fever	(2)	Renal disease
(3)	COPD, unstable	(3)	Liver disease	(4)	Acute renal failure
(2)	CVA	(4)	Malnutrition	(3)	Chronic renal failure
(2)	Dementia	(3)	Neurological disorders: coma	(3)	Spinal cord injury (SCI), new
(2)	Diabetes: controlled	(2)	Neurological disorders: others	(4)	Sepsis
(3)	Diabetes: uncontrolled	(2)	Nutritional anemia	(2)	Substance abuse
(3)	Diabetes: newly diagnosed	(2)	Pneumonia	(1)	Surgeries; all not mentioned
(3)	Dysphagia			(2)	Tuberculosis

**SECTION F. ALBUMIN LEVEL**

Put the patient's most RECENT Albumin level (g/dl) in box 1.						1.
Find the Albumin value in the table below and record the corresponding rating in BOX F. (g/dL)						
Alb.	No data OR > 6 Wks. old					
Rating	Leave Blank	1	2	3	4	
Place the actual Albumin RATING in BOX F.						F.
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX F'.						F'.

**SECTION G. TOTAL LYMPHOCYTE COUNT**

Place the patient's most RECENT TLC (cells/cmm) in BOX 1.						1.
Find the TLC value in the table below and record the corresponding rating in BOX G. (cells/cmm)						
TLC	No data OR > 6 Wks. old	>1500	1200-1499	800-1199	<799	
Rating	Leave Blank	1	2	3	4	
Place the actual RATING in BOX G.						G.
If you wish to adjust the rating based on other pt. information, place the ADJUSTED rating in BOX G'.						G'.

**OVERALL RATING** Transfer ratings of individual indicators to the following boxes.

ACTUAL	A	B	C	D	E	F	G	Determine an overall rating for the patient using your clinical judgment and place here.	<b>OVERALL</b>
ADJUSTED	A'	B'	C'	D'	E'	F'	G'		