

Please mark the correct boxes that apply to this patient



ABOUT YOUR PATIENT
SHEET 2a

Date

Center-Code

Unit-Code

Patient number Patient Initials Year of birth

Sex Female Male Date of admission

Weight lb. estimated measured

Height ft. in. estimated measured Patient consent Yes No

PLEASE CONTINUE ONLY IF PATIENT GAVE CONSENT!

1. This hospital admission was... planned an emergency I do not know

2a. Diagnosis at admission (mark all that apply)

- | | |
|--|---|
| <input type="checkbox"/> 0100 Infectious and parasitic diseases | <input type="checkbox"/> 1200 Skin and subcutaneous tissue |
| <input type="checkbox"/> 0200 Neoplasms | <input type="checkbox"/> 1300 Musculoskeletal system and connective tissue |
| <input type="checkbox"/> 0300 Blood and bloodforming organs and the immune mechanism | <input type="checkbox"/> 1400 Genitourinary system |
| <input type="checkbox"/> 0400 Endocrine, nutritional and metabolic diseases | <input type="checkbox"/> 1500 Pregnancy, childbirth and the puerperium |
| <input type="checkbox"/> 0500 Mental health | <input type="checkbox"/> 1600 Conditions originating in the perinatal period |
| <input type="checkbox"/> 0600 Nervous system | <input type="checkbox"/> 1700 Congenital/chromosomal abnormalities |
| <input type="checkbox"/> 0700 Eye and adnexa | <input type="checkbox"/> 1800 Symptoms, signs, abnormal clinical/lab findings |
| <input type="checkbox"/> 0800 Ear and mastoid process | <input type="checkbox"/> 1900 Injury, poisoning |
| <input type="checkbox"/> 0900 Circulatory system | <input type="checkbox"/> 2000 External causes of morbidity and mortality (e.g. transport accidents, assaults) |
| <input type="checkbox"/> 1000 Respiratory system | <input type="checkbox"/> 2100 Factors influencing health status and contact with health services |
| <input type="checkbox"/> 1100 Digestive system | |

2b. Main reason for admission (choose only one code from above)

3. Which conditions/comorbidities does this patient have? (mark an answer for each)

- | | |
|--|--|
| Cardiac insufficiency <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No |
| Myocardial infarction <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No |
| Chronic lung disease <input type="radio"/> Yes <input type="radio"/> No | Infection <input type="radio"/> Yes <input type="radio"/> No |
| Cerebral vascular disease <input type="radio"/> Yes <input type="radio"/> No | Dementia <input type="radio"/> Yes <input type="radio"/> No |
| Peripheral vascular disease <input type="radio"/> Yes <input type="radio"/> No | Major depressive disorder <input type="radio"/> Yes <input type="radio"/> No |
| Chronic liver disease <input type="radio"/> Yes <input type="radio"/> No | Other chronic mental disorder <input type="radio"/> Yes <input type="radio"/> No |
| Chronic kidney disease <input type="radio"/> Yes <input type="radio"/> No | Other chronic disease <input type="radio"/> Yes <input type="radio"/> No |

4a. Previous operation during this hospital stay

- Yes, planned No
- Yes, acute

days since operation days

4b. Planned operation during this hospital stay

- Yes, today or tomorrow
- Yes, later
- No

5. Previous ICU admission during this hospital stay? Yes No

6. Is this patient terminally ill? Yes No I do not know

7. Fluid status (TODAY) Normal Overloaded Dehydrated I do not know

8. Number of different medications planned (TODAY) oral other

9. Was this patient identified as malnourished or at risk of malnutrition? Malnourished At risk No I do not know

Please continue with Sheet 2b

Please mark the correct boxes that apply to the patient



ABOUT YOUR PATIENT
SHEET 2b

Date

Center-Code

Unit-Code

Patient number

Patients Initials

10. IV Fluids (TODAY) Electrolyte solution (NaCl, Ringers lactate, etc) 5% Glucose solution

11. Number of ONS drinks planned (TODAY)

12. Nutrition intake (TODAY) (mark an answer for each)

Regular hospital food	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Fortified/enriched hospital food	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Protein/energy supplement (e.g. ONS drinks)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Enteral nutrition	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Parenteral nutrition	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Special diet	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know

13a. All lines and tubes (TODAY) (mark an answer for each)

Central Venous	<input type="radio"/> Yes	<input type="radio"/> No	Nasoduodenal	<input type="radio"/> Yes	<input type="radio"/> No
Peripheral venous access	<input type="radio"/> Yes	<input type="radio"/> No	Enterostoma	<input type="radio"/> Yes	<input type="radio"/> No
Nasogastric	<input type="radio"/> Yes	<input type="radio"/> No	Percutaneous endoscopy/surgical gastrostomy	<input type="radio"/> Yes	<input type="radio"/> No
Nasojejunal	<input type="radio"/> Yes	<input type="radio"/> No	Percutaneous endoscopy/surgical jejunostomy	<input type="radio"/> Yes	<input type="radio"/> No

13b. Were there complications with nutrition related lines and tubes since admission? (infections /obstructions)

Yes, previously Yes, ongoing No I do not know

14. Please indicate if any of the following was done for this patient since admission (mark an answer for each)

Energy requirements were determined	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Protein requirements were determined	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Food/Nutrition intake was recorded in the patient record	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Nutrition treatment plan was developed	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Nutrition expert was consulted	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know
Malnutrition status is recorded in the patient record	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> I do not know

15a. Energy goal (YESTERDAY)

<500 kcal
 500-999 kcal
 1000-1499 kcal
 1500-1999 kcal
 >=2000 kcal
 Not determined
 I do not know

OR please insert kcal/lb

15b. Energy intake (YESTERDAY)

<500 kcal
 500-999 kcal
 1000-1499 kcal
 1500-1999 kcal
 >=2000 kcal
 Not determined
 I do not know

OR please insert kcal/lb

16. Since admission, this patient's health status has...

Improved This patient has just been admitted
 Deteriorated I do not know
 Remained the same

Thank you!