Step 1 Assessment: Medical Record Information

RESIDENT'S NAME_____

RESIDENT IDENTIFICATION NUMBER _____

STAFF INITIALS ___ ___ ___

PART A. DEMOGRAPHIC INFORMATION

1. MEDICAL RECORD ABSTRACTION DATE ____/____/____ mm dd yyyy
2. RESIDENT BIRTHDATE ____/____/____ mm dd yyyy
3. ADMISSION DATE to SKILLED NURSING FACILITY/UNIT ____/____/____ mm dd yyyy
4. SEX Male ____ Female ____
5. HEIGHT (inches) ____ inches
6. TUBE FEEDING No ____ Yes ____
   - IF YES, is tube-feeding: Supplemented by Oral _____ Sole feeding method ____
   - IF YES, Calories per cc _____ Cc per day ____
7. ORAL NUTRITIONAL SUPPLEMENT (e.g., Ensure, Resource) No ____ Yes ____
   - IF YES, Calories per cc _____ Cc per day ____
8. SPECIAL DIET No (Regular) ____ Yes ____
   - IF YES, Type of Diet (circle all the apply)
   - No Added Salt (NAS) No Concentrated Sugar (NCS) Mechanical-Soft Pureed
   - Small Portions Other *(specify):* _____
9. DENTURES No ____ Yes ____
10. DATE OF MOST RECENT ORAL/DENTAL EXAM ____/____/____ mm dd yyyy

PART B. MEDICAL AND PSYCHIATRIC DIAGNOSES **Check ALL that Apply**

HIV – AIDS	____
CANCER	____
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	____
CHRONIC RENAL FAILURE	____
CONGESTIVE HEART FAILURE	____
DEMENTIA	____
DEPRESSION	____
DIABETES	____
DYSPHAGIA	____
FAILURE TO THRIVE	____
GASTROINSTESTINAL DISORDERS	____
GI Bleeding	____
Diarrhea	____
Constipation	____
RECURRENT ASPIRATION PNEUMONIAS	____
RHEUMATOID ARTHRITIS	____
WEIGHT LOSS MALNUTRITION	____

PART C. ROUTINE MEDICATIONS with Appetite Suppressant Side Effects

Generic Name / Brand Name	**Check ALL that Apply**
AMLODIPINE / NORVASC	_____*
CONJUGATED ESTROGENS / PREMARIN	_____*
DIGOXIN / LANOXIN	_____*
ENALAPRIL MALEATE / VASOTEC	_____*
FAMOTIDINE / PEPCID	_____*
FENTANYL TRANSDERMAL SYSTEM / DURAGESIC	_____*
FUROSEMIDE / FUROSEMIDE	_____
IPRATROPIUM BROMIDE / ATROVENT	_____
LEVOTHYROXINE SODIUM / SYNTHROID / LEVOTHROID	_____
METFORMIN / GLUCOPHAGE	_____
NIFEDIPINE / PROCARDIA XL	_____*
NIZATIDINE / AXID	_____*
OMEPRAZOLE / PRILOSEC	_____*
PAROXETINE HCI / PAXIL	_____*
PHENYTOIN / DILANTIN	_____*
POTASSIUM REPLACEMENT / K-DUR	_____
RANITIDINE HCI / ZANTAC	_____*
RISPERIDONE / RISPERDAL	_____*
SERTRALINE HCI / ZOLOFT	_____*
WARFARIN / COUMADIN	_____

**May be Amenable to Substitution*

ROUTINE MEDICATIONS to Stimulate Appetite

Generic Name / Brand Name	**(Check ALL that Apply)**
CYPROHEPTADINE / PERI-ACTIN	_____
DRONABINOL	_____
MEGACE ACETATE	_____
MIRTAZEPINE / REMERON	_____
TESTOSTERONE (ANDRO-GEL OR INJECTIONS)	_____

NOTE: *These medications are not necessarily appropriate or recommended for use among nursing home residents. Please consult Primary Care Physician.*

PART D. RECENT LABORATORY VALUES RELEVANT TO NUTRITION

VALUE	*NORMAL RANGE*	*DATE OF MOST RECENT*	*NONE IN LAST MONTH*
BUN: _____mg/dL	(10-30)	_____/_____/_____ mm dd yyyy	_____
Cholesterol:_____mg/dL	(<200)	_____/_____/_____ mm dd yyyy	_____
Creatinine: _____mg/dL	(0.4-1.1)	_____/_____/_____ mm dd yyyy	_____
Serum Albumin: _____g/dL	(3.3-3.9)	_____/_____/_____ mm dd yyyy	_____
Serum Osmolality: _____osm	(270-310)	_____/_____/_____ mm dd yyyy	_____
Serum Sodium: _____mEq/L	(133-145)	_____/_____/_____ mm dd yyyy	_____
TSH: _____uIU/ml	(0.50-4.70)	_____/_____/_____ mm dd yyyy	_____
T4: _____ uIU/ml	(4.5-12.0)	_____/_____/_____ mm dd yyyy	_____

PART E. CURRENT WEIGHT AND WEIGHT CHANGE HISTORY

Date of Most Recent Weight: _____/_____/_____
mm dd yyyy

LATEST WEIGHT (pounds/date) _____ lbs.

WEIGHTS FOR 12 MONTHS PRIOR TO MOST RECENT WEIGHT OR ADMISSION

Date	Weight (pounds)
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____
_____/_____/_____ mm dd yyyy	_____

PART F. PHYSICAL AND COGNITIVE ABILITIES

EATING DEPENDENCY: (**in last 7 days**) _____ (0-4)

0=Independent (No help or staff oversight OR staff help/oversight provided only 1-2 times for resident to eat)

1= Supervision (Oversight, encouragement, or cueing provided 3 or more times OR supervision + physical assistance provided only 1-2 times)

2=Limited Assistance (Physical help in guided maneuvering to eat 3 or more times OR limited assistance + more help to eat provided only 1-2 times)

3=Extensive Assistance (full staff assistance provided 3 or more times for resident to eat)

4=Total Dependence (full staff assistance provided to resident for eating during entire seven day period)

COGNITIVE ABILITY: RECALL

Check all that Resident was Able to Accurately Recall (**in last 7 days**):

a. Current Season: ____
b. Location of Own Room: ____
c. Staff names and/or faces: ____
d. He/she is in a nursing home : ____

OR

e. None of the Above: ____

IF 2 OR MORE OF ITEMS a-d ARE CHECKED, PROCEED TO RESIDENT INTERVIEWS