

STEP 1 ASSESSMENT: MEDICAL RECORD INFORMATION

RESIDENT'S NAME: _____

STAFF NAME: _____

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 _____
- GASTROINTESTINAL 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 HCl / PAXIL	_____ *
PHENYTOIN / DILANTIN	_____ *
POTASSIUM REPLACEMENT / K-DUR	_____
RANITIDINE HCl / ZANTAC	_____ *
RISPERIDONE / RISPERDAL	_____ *
SERTRALINE HCl / 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

<i>VALUE</i>	<i>NORMAL RANGE</i>	<i>DATE OF MOST RECENT</i>	<i>NONE IN LAST MONTH</i>
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 _____

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_____/_____/_____
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, CONDUCT RESIDENT INTERVIEWS TO ASSESS CHRONIC PAIN, DEPRESSION, AND FOODS COMPLAINTS USING OUR *STEP 1 ASSESSMENT FORMS* ([link to w/forms](#)).