| NEMO Nutrition & Dietetics | | (Affix identification label here) | |
|--|---|------------------------------------|----------------------------|
| | | URN: | |
| | | Family name: | |
| DISCH | arge Report | Given name(s): | |
| | | Address: | |
| | | Date of birth: Sex | : |
| Date: | | | |
| To: | | | |
| Facility: | | | |
| Reason for nutrition r | eferral: | | Consented for referral |
| | | | to other service \square |
| ASSESSMENT | | | |
| Clinical (admission details, medical history, nutrition impact symptoms, allergies, medications as relevant) | | | |
| Anthropometry | Weight (kg): Height (cm): BMI (kg/m²): | | |
| | Weight hx: | | |
| Biochemistry (as relevant) | | | |
| Psychosocial (services, cognition, other) | | | |
| Estimated nutritional requirements | Estimated Energy Requiren Estimated Protein Requiren | | |
| | % of energy requirements n % of protein requirements n | net by current intake: | |
| Nutrition Summary | Diet requirements (e.g. HPI | <u>1E):</u> | |
| | <u>Diet texture:</u> ☐Full ☐Soft | ☐Minced & Moist ☐Pureed ☐ | Other |
| | Fluid thickness: Thin | Mildly Thick Moderately Thick | ☐Extremely Thick |
| | Supplement. Product/Amou | nt: | |
| | Repeats: | Script expiry date: | |
| | ☐ Self purchase ☐ Scri | ot: Hospital / HENS – Brightsky or | Nutricia / Private |
| | ☐ Disadvantaged / Financia | al hardship 🔲 DVA | |
| | | | *Please attach |



| Feeding regime (if | Type / size of tube: | | | |
|--------------------------------------|--|--|--|--|
| relevant) | Type of button (if relevant): | | | |
| ☐ Not Applicable | ☐ Nasogastric ☐ Nasojejunal ☐ Gastrostomy ☐ PEG-J ☐ Jejunostomy | | | |
| | Insertion method | | | |
| | ☐ Endoscopy ☐ Radiology ☐ Surgically ☐ Other | | | |
| | <u>Date inserted</u> : | | | |
| | Equipment required: Formula name: | | | |
| | Bolus (mL) / Continuous Rate (mL/hr): | | | |
| | Time: | | | |
| | Water flushes: Energy: kJ/kg/day = | | | |
| | Protein: g/kg/day = | | | |
| | Fluid: ml/kg/day = | | | |
| | *Please attach script* | | | |
| SGA/PG-SGA | ☐ SGA A - Well Nourished ☐ At risk of malnutrition | | | |
| Date: | SGA B - Mild-moderately Malnourished | | | |
| | ☐ SGA C - Severely Malnourished PG-SGA score: | | | |
| NUTRITION DIAGNOSIS | | | | |
| Nutrition | | | | |
| Diagnosis | | | | |
| (PESS) | | | | |
| INTERVENTION | | | | |
| Summary of | | | | |
| intervention and | | | | |
| education | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| MONITORING & EVALUATION | | | | |
| Recommended | | | | |
| nutrition plan for | | | | |
| discharge: Patient and/or carer | | | | |
| has been consulted | | | | |
| in the development | | | | |
| of care plan □ | | | | |
| Recommended review date for | Please email to acknowledge receipt of referral to referring dietitian | | | |
| follow up | ☐ Please provide summary of review appointment to referring dietitian | | | |
| | | | | |
| Home visit alerts/ considerations | | | | |
| Best contact | ☐ Patient ☐ Family / friend ☐ Nursing Home / facility staff ☐ Carer Name: Phone: | | | |
| Distition contest | | | | |
| Dietitian contact information | Name: Hospital / Community Health Centre: | | | |
| □ Copy provided to | Phone number: Fax number: | | | |
| patient | Email: | | | |

