M30H24
Rev. 6/13

Duke University Hospital
DUKE UNIVERSITY HEALTH SYSTEM

NUTRITION SCREENING QUESTIONS

Addressograph

Name
History number (inpatient)
Birthdate (clinics and PDC)

You are kindly being asked to provide this information to help us determine whether a nutritional consult is needed. Please be aware that you may request to see a dietitian at any time during your treatment, as they will gladly be available to help. Thank you.

Patient to complete:

Date _____ **Time** _____

Reason for visit _____ **Current height** _____ **Current weight** _____

1. Have you lost more than 15 pounds over the past 6 months? ☐ YES ☐ NO
2. Have you experienced a rapid weight gain? ☐ YES ☐ NO
3. Are you receiving tube feeds? ☐ YES ☐ NO
4. Are you having the following problems which have caused you to eat less than normal over the past 2 weeks?

Nausea	☐ YES ☐ NO
Vomiting	☐ YES ☐ NO
Diarrhea	☐ YES ☐ NO
Constipation	☐ YES ☐ NO
Mouth sores	☐ YES ☐ NO
Poor appetite	☐ YES ☐ NO
Difficulty swallowing foods or beverages?	☐ YES ☐ NO

(Scoring area) Nursing to fill out

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Scoring

- Question 1: yes (3 points)
- Question 2: yes (1 point)
- Question 3 yes (3 points)
- Question 4: each yes (1 point)

Total number of points: _____

*If total score = **3** (or greater), a nutrition consult is indicated*

☐ Patient has declined nutritional consult at this time

Staff Member completing tool; please sign below

Signature:_____ Title:_____ Pager #:_____ Date:_____ Time:_____