NEMO Nutrition & Dietetics Discharge Report	(Affix identification label here) URN: Family name: Given name(s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Date:

To:

Facility:

Reason for nutrition referral:	**Consented for referral to other service** ☐

ASSESSMENT

Clinical (admission details, medical history, nutrition impact symptoms, allergies, medications as relevant)	
Anthropometry	Weight (kg): Height (cm): BMI (kg/m^2): Weight hx:
Biochemistry (as relevant)	
Psychosocial (services, cognition, other)	
Estimated nutritional requirements	Estimated Energy Requirement: Estimated Protein Requirement: % of energy requirements met by current intake: % of protein requirements met by current intake:
Nutrition Summary	Diet requirements (e.g. HPHE): Diet texture: ☐Full ☐Soft ☐Minced & Moist ☐Pureed ☐ Other Fluid thickness: ☐Thin ☐Mildly Thick ☐Moderately Thick ☐Extremely Thick Supplement. Product/Amount: Repeats: Script expiry date: ☐ Self purchase ☐ Script: Hospital / HENS – Brightsky or Nutricia / Private ☐ Disadvantaged / Financial hardship ☐ DVA ***Please attach**

Reviewed: September 2017
Due for review: September 2019

Queensland Government

Feeding regime (if relevant) ☐ Not Applicable	Type / size of tube: Type of button (if relevant): ☐ Nasogastric ☐ Nasojejunal ☐ Gastrostomy ☐ PEG-J ☐ Jejunostomy Insertion method ☐ Endoscopy ☐ Radiology ☐ Surgically ☐ Other Date inserted: 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 Date:	☐ SGA A - Well Nourished ☐ At risk of malnutrition ☐ 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 follow up	☐ Please email to acknowledge receipt of referral to referring dietitian ☐ 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:
Dietitian contact information □ Copy provided to patient	Name: Hospital / Community Health Centre: Phone number: Fax number: Email: