

Nutrition Screen & Referral Criteria for Adults (18+ Years) with HIV/AIDS^{1,2}

Today Date _____

Name _____ Phone _____ Messages: Yes No Discreet

Gender _____ Language _____ DOB ____/____/____ Age _____ File # _____

Medicaid Waiver Client? Yes No Insurance _____ Case Managed By _____

Referred By _____ Date _____ Phone _____

Screen every six months and/or per status change. Automatically refer to a registered dietitian for any of the following:
(Check all that apply)

| | | |
|--|---|---|
| A. Diagnosis and Nutrition Assessment | | |
| 1. | <input type="checkbox"/> | Newly diagnosed HIV infection |
| 2. | <input type="checkbox"/> | Newly diagnosed with AIDS |
| 3. | <input type="checkbox"/> | Any change in disease or nutritional status |
| 4. | <input type="checkbox"/> | No nutrition assessment by a registered dietitian or not seen by a registered dietitian in six months |
| B. Physical Changes and Weight Concerns | | |
| 1. | <input type="checkbox"/> | > 3% unintentional weight loss from usual body weight in the last 6 months or since last visit (% wt. loss formula: usual body wt – current body wt / usual body wt x 100) |
| 2. | <input type="checkbox"/> | Visible wasting, < 90% ideal body weight, < 20 BMI, or decrease in body cell mass (BCM) |
| 3. | <input type="checkbox"/> | Uses anabolic steroids or growth hormone for weight, muscle gain or metabolic complications |
| 4. | <input type="checkbox"/> | Lipodystrophy: lipoatrophy, central fat adiposity and/or fat accumulation on the neck, upper back, breasts or other areas. |
| 5. | <input type="checkbox"/> | Abdominal obesity: Waist circumference > 102cm (40 in) for male and >88cm (35 in) for female |
| 6. | <input type="checkbox"/> | Client or MD initiated weight management, or obesity: BMI > 30 |
| C. Oral/GI Symptoms | | |
| 1. | <input type="checkbox"/> | Uses an appetite stimulant or suppressant |
| 2. | <input type="checkbox"/> | Loss of appetite, desire to eat or poor oral intake of food or fluid for > 3 days |
| 3. | <input type="checkbox"/> | Missing teeth, severe dental caries, difficulty chewing, swallowing |
| 4. | <input type="checkbox"/> | Mouth sores, thrush, or mouth, tooth or gum pain |
| 5. | <input type="checkbox"/> | Persistent diarrhea, constipation or change in stools (color, consistency, frequency, smell) |
| 6. | <input type="checkbox"/> | Persistent nausea or vomiting |
| 7. | <input type="checkbox"/> | Persistent gas, bloating or heartburn |
| 8. | <input type="checkbox"/> | Changes in perception of taste or smell |
| 9. | <input type="checkbox"/> | Food allergies or food intolerance's (fat, lactose, wheat, etc.) |
| 10. | <input type="checkbox"/> | Medication involving food or meal modification |
| 11. | <input type="checkbox"/> | Need for enteral or parenteral nutrition |
| D. Metabolic Complications & Other Medical Conditions | | |
| 1. | <input type="checkbox"/> | Diabetes Mellitus, impaired glucose tolerance, impaired fasting glucose, insulin resistance, or hypo or hyperglycemia |
| 2. | <input type="checkbox"/> | Hyperlipidemia: cholesterol >200mg/dL, triglycerides ≥150mg/dL, LDL >130g/dL, &/or HDL<40 mg/dL (men) <50 (women) |
| 3. | <input type="checkbox"/> | Hypertension: three BP readings ≥ 135/85 mmHg or diagnosed with HTN |
| 4. | <input type="checkbox"/> | Hepatic Disease: Hepatitis C, Hepatitis B, cirrhosis, steatosis, or other: _____ |
| 5. | <input type="checkbox"/> | Osteopenia/osteoporosis risk: per elevated alkaline phosphatase, DEXA of the hip & spine low T-scores |
| 6. | <input type="checkbox"/> | Other conditions: renal disease, anemia, heart disease, pregnancy, cancer or other: _____ |
| 7. | <input type="checkbox"/> | Albumin < 3.5 mg/dL, prealbumin < 19 mg/dL, or cholesterol <120 mg/dL |
| 8. | <input type="checkbox"/> | Scheduled chemotherapy or radiation therapy |
| E. Barriers To Nutrition, Living Environment, Functional Status | | |
| Usually or always needs assistance with: | Patient is: | |
| 1. <input type="checkbox"/> Eating | 4. <input type="checkbox"/> Homebound | 7. <input type="checkbox"/> Has limited or no cooking skills |
| 2. <input type="checkbox"/> Preparing food | 5. <input type="checkbox"/> Homeless | 8. <input type="checkbox"/> Lives on income of < \$6,000/yr |
| 3. <input type="checkbox"/> Shopping for food & necessities | 6. <input type="checkbox"/> Unable to secure food | 9. <input type="checkbox"/> Has no stove or refrigerator |
| F. Behavioral Concerns or Unusual Eating Behaviors | | |
| 1. | <input type="checkbox"/> | Binges, purges, purposely skips meals, or avoids eating when hungry |
| 2. | <input type="checkbox"/> | Consumes > two alcoholic beverages/day |
| 3. | <input type="checkbox"/> | IVDU or recreational drug use |
| 4. | <input type="checkbox"/> | Vegetarianism |
| 5. | <input type="checkbox"/> | Client initiated vitamin/mineral supplementation > RDA, or complimentary or alternative diet related therapies |

1 Adapted from: Fenton M, Heller L, Vazzo L, et al. Dietitians in AIDS Care, AIDS Project Los Angeles, 1998. Nutrition screening referral criteria included in: *Guidelines for Implementing HIV/AIDS Medical Nutrition Therapy Protocols*. Approved by the Los Angeles County Commission on HIV Health Services, September 1999.
2 Adapted from the C.A.R.E. Program and Clinics – Catholic Healthcare Org, a Ryan White CARE Act Title III Grantee providing early intervention services and primary health care to people living with HIV and AIDS in Long Beach, CA; developed by Tammy Darke, RD, CNSD. Adapted by Fenton M, 5/2000, then by the ADA HIV/AIDS DPG special working groups members, 2002.
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Medical Information

Referring Physician: _____ Phone #: _____

Address: _____

HIV Diagnosis Date: _____ AIDS Diagnosis: Yes No If yes, Date: _____

Other Medical Diagnosis: _____

Current Medications (dose, frequency including supplements): _____

AIDS defining illnesses: _____

Past Medical History: _____

Karnofsky Score: _____ Physical activity clearance: Yes No Restrictions: _____

Additional Information (eg: smokes, alcohol use, etc.) _____

Current Lab Values/Measurements
(Include below with date or attach recent copy)

WBC
 RBC
 Hgb
 Hct
 MCV
 MCH
 Sodium
 Potassium
 Chloride
 Total CO2
 BUN
 Creatinine
 Glucose (___fasting ___random)
 Fasting Insulin
 Glycated HbA1c

Albumin
 Prealbumin
 AST
 ALT
 Alkaline Phosphatase
 Testosterone (total)
 Testosterone (free)
 Lactic Acid
 B12
 Folate
 Other (_____)

Lipids (___fasting ___non-fasting)
 Total Cholesterol
 LDL-Cholesterol (direct/indirect)
 HDL-Cholesterol
 Triglycerides
 C-reactive Protein (ultrasensitive)

Virology/Immunology

HIV RNA/ml
 Highest RNA/ml (date: _____)
 CD4
 Nadir CD4 (date: _____)
 Other (_____)

Measurements

Height (in.)
 Weight (lbs)
 Usual body weight (lbs)
 Body composition result (attached)
 DEXA hip T-score
 DEXA spine T-score
 Other (_____)

Documentation that must be provided to the registered dietitian by referring agency

In addition to completing the Nutrition Screen & Referral Criteria, Medical Information and Current Labs/Measurement sections, the dietitian must have the following documentation before an appointment can be made.

1. Signed copy of patient's consent to release medical information
2. Signature of physician or individual authorized by state to refer for medical nutrition therapy
3. Nutrition prescription
4. Proof of residency and income if required for program eligibility

Physician's order for medical nutrition therapy provided by a registered dietitian**Comments:**

Signature of physician or individual authorized by state to refer for medical nutrition therapy _____ Date _____