Republic of the Philippines
Department of Health
**OFFICE OF THE SECRETARY**

AUG 2 8 2019

**ADMINISTRATIVE ORDER**
No. 2019- 0033

**SUBJECT: Guidelines for the Implementation of Nutrition Care Process in Hospitals**

## I. RATIONALE

The Republic Act No. 10862 or the Nutrition and Dietetics Law of 2016 was enacted to regulate and standardize the practice of nutrition and dietetics in the Philippines, with a provision on Medical Nutrition Therapy (MNT) through the application of Nutrition Care Process (NCP) for purposes of disease prevention, treatment, and management. According to the Academy of Nutrition and Dietetics, NCP is the systematic problem-solving method that dietetics professionals utilize to critically think and make decisions to address nutrition-related problems and provide safe and effective quality nutrition care. Four equally important steps, known as ADIME, are included in NCP namely (1) Assessment, (2) Diagnosis, (3) Intervention, and (4) Monitoring and Evaluation. NCP is designed to improve the consistency and quality of nutrition care and the predictability of the nutrition outcome; it is not intended to standardize nutrition care for patients but to establish a standardized process for providing MNT, which utilizes NCP in disease prevention, treatment, and management.

Currently, nutrition services are delivered in several and varied modalities depending on the level of competency and nutrition and dietetic practices of Registered Nutritionists-Dietitians (RNDs), hospital facilities, and resources. Although screening patients for malnutrition risk on hospital admission is a standard of care, nutrition shortfalls are not always addressed. The treatment of patients who are nutritionally-at-risk offers a tremendous opportunity to optimize the overall quality of patient care, to improve clinical outcomes, and to reduce cost. Unfortunately, nutritionally-at-risk patients continue to be unrecognized in many hospitals. Many patients have deteriorating nutrition status during their hospital stay, including those who were adequately nourished on admission as well as those who entered the hospital malnourished.

In line with the National Nutrition Council's mandate of formulating an integrated national program on nutrition, and relative to the Universal Health Care Act and Department of Health's FOURmula One Plus for Health, the provision of high quality and affordable nutrition care presents many challenges to hospital-based health professionals. There is a need to call for action for interdisciplinary approach for a coordinated service delivery to recognize the performance accountability of RNDs in administering prompt MNT. It is important to take an efficient regulatory mechanism to achieve transparent governance for sustainable financing health and nutrition care delivery.

## II. OBJECTIVE

This Order shall provide guidelines in the implementation of Nutrition Care Process (NCP) in public and private hospitals.

## III. SCOPE AND COVERAGE

This Order shall provide the mandate and direction for public and private hospitals to operationalize and institutionalize the Nutritional Care Process in their respective facilities.

## IV. DEFINITION OF TERMS

1. **Malnutrition** refers to deficiencies, excesses, or imbalances in the intake of energy and/or nutrients of a person.
2. **Registered Nutritionist-Dietitian (RND)** holds a valid certificate of registration and a valid professional identification card, which is renewed every three years and issued by the Board of Nutrition and Dietetics of the Professional Regulation Commission, pursuant to Republic Act No. 10862 or the Nutrition and Dietetics Law of 2016.
3. **Nutritional Care** is an organized group of activities allowing the identification of nutritional needs and provision of care to meet these needs.
4. **Nutrition Care Process (NCP)** is the systematic problem-solving method that dietetics professionals utilize to critically think and make decisions to address nutrition-related problems and provide safe and effective quality nutrition care.
5. **Nutritionally-at-risk patients** are considered at-risk if they have any of the following:
   a. Actual or potential for developing malnutrition (involuntary loss or gain $\geq$10% of usual body weight within 6 months, or $\geq$5% of usual body weight in 1 month, a weight of 20% over or under ideal body weight); presence of chronic disease, or increased metabolic requirements;
   b. Altered diets or diet schedules (receiving total parenteral or enteral nutrition, recent surgery, illness, or trauma); and
   c. Inadequate nutrition intake including those not receiving food or nutrition products (impaired ability to ingest or absorb food adequately) for greater than 7 days.
6. **Critically-ill patients** are usually those patients at the Intensive Care Unit (ICU), geriatric, stroke, and cancer patients, and those with pre- and post-operative conditions.
7. **Medical Nutrition Therapy (MNT)** is the application of NCP for purposes of disease prevention, treatment, and management.

## V. IMPLEMENTING MECHANISM

### A. General Guidelines

The following guidelines shall be implemented to operationalize and institutionalize NCP at all levels of public and private hospitals:

1. Nutrition screening is the prerequisite to the implementation of NCP in identifying nutritionally-at-risk patients, including those who are critically-ill. All patients admitted to the hospitals shall be screened by nurses to identify those who are nutritionally-at-risk using a nutrition screening tool *(See Annex A1 for Adult and Annex A2 for Pediatric)*. Based on standards of patient care, patients who are "nutritionally-at-risk" shall be identified immediately.
2. Upon nutrition screening accomplished by the nurse, referral for Medical Nutrition Therapy (MNT) to the RND shall be accomplished by the physician on duty.
3. Nutrition and Dietetics Service/Department, headed by an RND, shall ensure that the delivery of NCP is of utmost quality designed to provide standardized process in individual patient health care at all stages: assessment, diagnosis, intervention, and monitoring and evaluation. Nutrition Care Plan shall be accomplished using *Annex B*.
4. The hospital shall provide adequate human resources for health complement by complying with the staffing pattern prescribed by the latest joint issuance of the Department of Budget and Management (DBM) and DOH, i.e., DBM-DOH Joint

Circular No. 2013-1 or the Revised Standards on Organizational Structure and Staffing Pattern of Government Hospitals, CY 2013 Edition.

5. A flowchart and a table of subsequent steps in nutrition care algorithm, with corresponding explanations, illustrated in *Annex C*, shall be utilized as standard algorithm for NCP. All annexes can be downloaded at **bit.ly/DOHNutritionCareProcess**.

6. A bi-annual accomplishment report of nutritionally-at-risk patients done in accordance with the different steps in the NCP shall be prepared by the RND and be submitted to the Medical Records Section under the Health Information and Management Service for verification. A duplicate copy shall be kept for reference *(See Annex D for the reporting template).*

## B. Specific Guidelines

### 1. Nutrition Care Algorithm

a. Nutrition screening, as the prerequisite to the implementation of NCP in identifying nutritionally-at-risk patients through certain parameters (i.e., anthropometric measures, dietary intake, and clinical condition), shall be accomplished by the staff nurse (RN) upon admission of patient in the hospital using validated nutrition screening tools *(See Annexes A1 and A2)*. Hence, all patients shall be screened either at-risk or not-at-risk. Hospitals using electronic health record (EHR) system shall create an automatic referral system to the RND. Identified not-at-risk patients shall undergo periodic re-screening to determine as totally not-at-risk or at-risk.

b. Upon nutrition screening, the physician on duty shall refer patients needing MNT to the RND using *Annexes A1* and *A2* for adult and for pediatric, respectively.

c. All nutrition referrals shall be accommodated by the RND within 24-48 hours after admission. MNT shall be implemented using *Annex B*.

d. The RND shall initiate nutrition assessment to the nutritionally-at-risk patients referred to by the physician on duty. The RND shall collect, classify, analyze, and interpret patient's data compared to accepted standards such as anthropometric, growth charts, dietary guidelines, metabolic panels, and other relevant data contributing to the potential nutrition-related problems. Based on the nutrition assessment, patients shall be categorized, by risk, as follows:
   i. High Risk: Patients identified to have severe malnutrition and have "high risk" in developing malnutrition and nutrition-related complications including all critically-ill patients, and shall receive nutritional care within 24 hours;
   ii. Moderate Risk: Patients identified to have "moderate risk" in developing malnutrition and nutrition-related complications; and
   iii. Low Risk: Patients admitted for >15-day length of stay shall be re-assessed.

e. Nutrition diagnosis shall be determined based on the evaluation of all the information obtained from the nutrition assessment by the RND. Accuracy of nutrition diagnosis shall be guided by critical evaluation of each component of the assessment. It may lead to nutrition intervention for improving nutrition status, such as change in diet, enteral or parenteral nutrition, or further medical assessment. Nutrition assessment shall provide basis for the development of nutrition care plan, which shall be implemented subsequently. As shown in *Annex C*, clinical assessment (including rescreening and reassessment) is a continuous process.

f. Nutrition interventions shall be the basis for the development of MNT and implementation. It shall involve development of MNT and implementation. Total

Energy Requirement (TER), macronutrient distribution, and meal plan containing sample menu shall be accomplished per patient.

g. Nutrition monitoring and evaluation shall determine the degree to which progress is being made and goals or desired outcomes are being met.

**2. Roles and Responsibilities**

a. The **Health Facility Development Bureau (HFDB)** of DOH shall be the national oversight in the implementation of this Order based on its mandate in providing technical assistance to hospitals. It shall coordinate and provide technical inputs for the operationalization this Order and other relevant initiatives. It shall convene series of consultations with relevant offices in DOH on how to include the implementation of this Order as part of minimum licensing requirements of a hospital. It shall provide reports on the implementation of this Order to relevant clusters in DOH.

b. The **Centers for Health Development (CHDs), through the Regional RNDs,** shall:
a. ensure the implementation of this Order in all hospitals within its catchment area;
b. conduct monitoring and evaluation of this Order within its catchment area; and
c. consolidate and submit reports from LGU Hospitals within its catchment area to HFDB.

c. **All public and private hospitals** shall provide necessary logistics and management support and shall strictly comply with the implementation of this Order. The roles and responsibilities of the following hospital staff are as follows:

i. The **attending physician** shall
1. refer all cases needing MNT to RNDs;
2. conform and duly sign the NCP recommendations developed by the RND;
3. lead in the administration of care plan provided by the RNDs, nurses, pharmacists, and other allied health professionals;
4. conduct nutrition support access; and
5. actively convene interdisciplinary conferences to present results of managed cases.

ii. The **registered nutritionist-dietitian** shall
1. develop nutrition care plan for nutritionally-at-risk and critically-ill patients;
2. implement the nutrition care plan;
3. monitor, evaluate, and document the nutrition care plan to determine progress and nutrition outcome of the interventions;
4. prepare bi-annual accomplishment report and submit such report to the hospital health information management service worker and to HFDB; and
5. actively participate in case conferences, e.g. ward rounds and interdisciplinary health care planning.

iii. The **registered nurse** shall
1. complete nutrition screening upon admission;
2. carry-out the prescribed medications, diet and fluid requirements, and diagnostic tests related to nutrition care;
3. prepare and update diet list for submission to the Nutrition and Dietetics Service/Department; and
4. document changes in eating/drinking patterns in the patient's chart and tolerance/intolerance to certain foods, and discuss such matters with the RND.

iv. The **registered pharmacist or registered clinical pharmacist** shall
1. discuss with RND for food/nutrient and drug interaction; and
2. participate in case conferences and interdisciplinary planning of healthcare team.

v. The **registered social worker** shall
   1. provide psychosocial interventions to patients and their families; and
   2. facilitate referral of patients needing financial assistance relative to health and nutrition care needs.

vi. The **hospital health information management service worker** shall provide necessary technical assistance to the RND in the preparation of bi-annual hospital nutrition care process reporting form and timely submission to HFDB.

d. The **Professional Regulation Commission (PRC)** shall actively participate in the monitoring, evaluation, and proper practice of RNDs in compliance with Republic Act No. 10862 or the Nutrition and Dietetics Law of 2016.

e. The **Field Implementation and Coordination Team (FICT)** shall be the over-all in-charge with respect to monitoring for the effective and efficient implementation of this Order in all government hospitals and shall host a regular meeting with stakeholders to address issues and concerns in the implementation of this Order.

**3. Monitoring and Evaluation**

a. The HFDB Dietary Adviser shall lead in the monitoring and evaluation in coordination with the Health Information Management Service Adviser of HFDB.

b. DOH hospitals shall submit bi-annual reports to HFDB, and likewise LGU Hospitals to the CHDs. The consolidated bi-annual reports of CHDs shall be submitted to HFDB. On the other hand, private hospitals shall submit bi-annual reports to HFDB. Submission of bi-annual reports, using *Annex D,* to HFDB from DOH hospitals, from CHDs, and from private hospitals shall be every 15th day of the month following the last month of each semester, i.e. July 15th and January 15th for first and second semesters, respectively, through uploading of reports via Google Drive at **bit.ly/DOHNutritionCareProcess** (Note that each text is case-sensitive.).

c. HFDB shall consolidate all reports and analyze its implications on the implementation of this Order. It shall also provide bi-annual technical advice to DOH hospitals, to CHDs, and to relevant offices in DOH for the compliance of hospitals to this Order.

d. All consolidated reports at all levels shall be a basis for research and development activities and program enhancements in all hospitals or health care facilities.

## VI. REPEALING CLAUSE

All previous Orders not consistent with this Order are hereby rescinded.

## VII. EFFECTIVITY

This Order shall take effect immediately.

**FRANCISCO T. DUQUE III, MD, MSc**
Secretary of Health

*(Name of Hospital)*

# ADMISSION ADULT

## *Nutrition Screening and Referral Tool*

Name of Patient: _____ Age: _____ Sex: _____

Address: _____ Height: _____ Weight: _____

**Instructions:** Mark each box appropriate to the patient. If the patient has at least ONE of the following conditions and/or histories, refer to the Registered Nutritionist-Dietitian for Medical Nutrition Therapy; otherwise, RESCREEN after three (3) days.

| **A. CLINICAL CONDITION** | |
|---|---|
| ☐ Admission to ICU | ☐ Malabsorption (celiac sprue, ulcerative colitis, Crohn's disease, short bowel syndrome) |
| ☐ Anorexia Nervosa/Bulimia Nervosa | ☐ Multiple Trauma (closed head injury, penetrating trauma, multiple fractures) |
| ☐ Cachexia (temporal wasting, muscle wasting, cancer, cardiac) | ☐ Non-healing wounds, Pressure Injury |
| ☐ Cerebrovascular accident | ☐ On tube feeding/parenteral nutrition |
| ☐ Coma | ☐ Renal Disease (acute, chronic, undergoing dialysis) |
| ☐ Diabetes Mellitus/Gestational Diabetes Mellitus | ☐ Sepsis |
| ☐ Gastrointestinal disease or complication | ☐ Serum albumin <3.5 gm/L |
| ☐ Liver disease | |
| **B. INTAKE/WEIGHT HISTORY** | |
| ☐ Unintentional weight loss in the past 3 months | ☐ Pregnant patient is aged ≤ 18 years old or ≥ 35 years old |
| ☐ Reduced dietary intake in the past week | ☐ Pregnancy with Hyperemesis gravidarum/ Pregnancy-Induced Hypertension |
| ☐ BMI below 18.5 and above 30 *(to be computed by the RND)* | ☐ Multiple Pregnancy |
| | ☐ Lactating Mother |

***Reference:*** *Kovacevich, Debra S.; Boney, Anthony R.; Braunschweig, Carol L.; Perez, Anne; Stevens, Mary (1997). "Nutrition Risk Classification: A Reproducible and Valid Tool for Nurses." Nutrition in Clinical Practice 12(1): 20-25.*

***Accomplished by:***

_____ _____

Signature over **PRINTED NAME** of the Nurse Date/Time

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*(Name of Hospital)*

## REFERRAL FOR MEDICAL NUTRITION THERAPY

Diagnosis: _____

Diet Prescription: _____

☐ *Per Orem* ☐ *Tube Feeding* ☐ *NPO/TPN*

***Referred by:***

_____ _____

Signature over **PRINTED NAME** of the Physician Date/Time

*(Name of Hospital)*

# ADMISSION PEDIATRIC

## *Nutrition Screening and Referral Tool*

Name of Patient: _____ Age: _____ Sex: _____
Address: _____ Height: _____ Weight: _____

**Instructions:** Mark each box appropriate to the patient. If the patient has at least ONE of the following conditions and/or histories, refer to the Registered Nutritionist-Dietitian for Medical Nutrition Therapy; otherwise, RESCREEN after three (3) days.

| **A. CLINICAL CONDITION** | |
|---|---|
| ☐ Admission to ICU<br>☐ Anorexia Nervosa/Bulimia Nervosa<br>☐ Cachexia (temporal wasting, muscle wasting, cancer, cardiac)<br>☐ Cerebrovascular accident<br>☐ Coma<br>☐ Congenital anomalies (e.g. Down's Syndrome, Craniofacial anomalies, Spina bifida, Hydrocephalus, Chiari Malformation)<br>☐ Diabetes Mellitus/Gestational Diabetes Mellitus<br>☐ Gastrointestinal disease or complication/ impending GI surgery (e.g. Pancreatitis, Inflammatory Bowel Disease, GERD, Malabsoroption conditions, Crohn's Disease<br>☐ Inborn errors of metabolism<br>☐ Inflammatory diseases (e.g. Sepsis, Encephalitis, Meningitis, Kawasaki | Disease, Enterocolitis, Community-acquired pneumonia, Upper/Lower Respiratory Tract Infection)<br>☐ Liver disease<br>☐ Malabsorption (celiac sprue, ulcerative colitis, Crohn's disease, short bowel syndrome)<br>☐ Multiple Trauma (closed head injury, penetrating trauma, multiple fractures)<br>☐ Neurologically-challenged (e.g. ADHD, Cerebral palsy, seizure disorders, Infantile spasms)<br>☐ On tube feeding/parenteral nutrition<br>☐ Renal Disease (acute, chronic, undergoing dialysis)<br>☐ Sepsis<br>☐ Serum albumin <3.5 gm/L |
| **B. INTAKE/WEIGHT HISTORY** | |
| ☐ Unintentional weight loss in the past 3 months<br>☐ Patient on breastmilk feeding<br>☐ Reduced dietary intake in the past week<br>☐ Reduction of dietary intake in the past week/s and/or during the hospital stay<br>☐ For patients ages >5 years old to <18 years old, 364 days:<br>☐ BMI z-scores above +2 and below -2 *(c/o RND)* | ☐ For patients ages >2 – 5 years old:<br>○ Weight for Height z-scores above +2 and below -2 *(c/o RND)*<br><br>☐ For patients ages 1 month – 2 years old:<br>○ Weight for Length z-scores above +2 and below -2 *(c/o RND)* |

***Reference:*** *Kovacevich, Debra S.; Boney, Anthony R.; Braunschweig, Carol L.; Perez, Anne; Stevens, Mary (1997). "Nutrition Risk Classification: A Reproducible and Valid Tool for Nurses." Nutrition in Clinical Practice 12(1): 20-25.*

***Accomplished by:***

_____ _____
Signature over **PRINTED NAME** of the Nurse Date/Time

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*(Name of Hospital)*

## REFERRAL FOR MEDICAL NUTRITION THERAPY

Diagnosis: _____
Diet Prescription: _____

☐ *Per Orem* ☐ *Tube Feeding* ☐ *NPO/TPN*

***Referred by:***

_____ _____
Signature over **PRINTED NAME** of the Physician Date/Time

(Name of Hospital)

## NUTRITION AND DIETETICS SERVICE
### Medical Nutrition Therapy Form
### (Nutrition Care Plan)

Name of Patient (Last, First, MI):_____ Hospital Number:____Age:____Gender:___
Name of Attending physician:_____ Date of Admission:_____
Diagnosis:_____ Religion:_____

**NUTRITION ASSESSMENT**

Present Diet of Patient:_____

**Food Intake:**
_____ No change
_____ Mostly Liquids
_____ Sub-Optimal
_____ Starvation
_____ Poor intake prior to admission

**Functional capacity:**
_____ Bedridden
_____ Ambulatory
_____ Needs assistance

Chewing/Swallowing Difficulties:_____
Constipation:_____Diarrhea:_____
Food Allergies:_____
Food intolerance:_____

**Medications:**

Height:_____ (cm) Weight: _____ (kg)
Usual weight:_____(kg) BMI:
Weight change:_____% over _____weeks/months
% IBW: _____

**Biochemical Data**

| | |
|---|---|
| Albumin: | Hemotocrit: |
| BUN: | Hemoglobin: |
| Calcium: | LDL: |
| Cholesterol: | Phosphate: |
| Creatinine: | Potassium: |
| Glucose:: | Sodium: |
| HbA1C: | Triglycerides: |
| HDL: | URR: |

**Others:** _____
BP: _____ Acid Base Gas (ABG): _____

**NUTRITIONAL STATUS:**

☐ Normal ☐ Moderate Malnutrition ☐ Severe Malnutrition

**NUTRITION DIAGNOSIS (Problem, Etiology, Signs, and Symptoms)**

_____ related to_____
_____as evidenced by _____.

**NUTRITION INTERVENTION**

Total Energy Requirement: _____
Carbohydrate grams/day:_____Protein grams per day:_____Fat grams/day:_____
Others (e.g. micronutrients):_____
☐ Shift diet to: ( ) Per Orem ( ) Tube Feeding ( ) TPN
☐ Nutrition Education on _____
☐ Request for Laboratory Results:_____ ☐ Others:_____

**NUTRITION MONITORING AND EVALUATION**

☐ Adequacy of intake: ( ) Calories ( ) Protein ( ) Fluid
☐ GI Tolerance
☐ Compliance to Diet
☐ Weight Changes

_____
_____

***Recommended by:***

_____*(signature)*_____
(PRINTED NAME of RND)

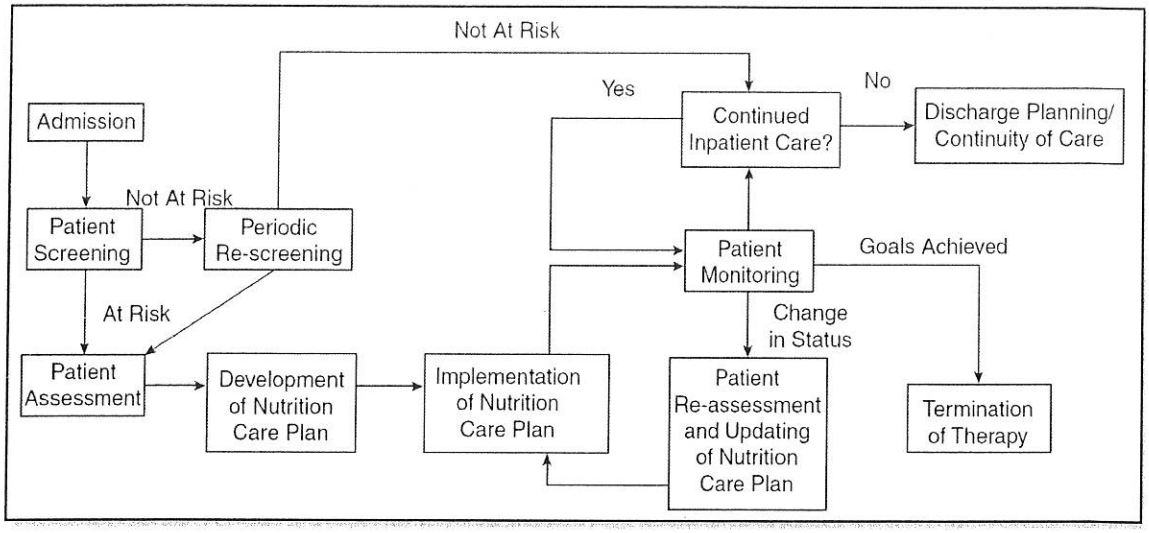
***Conforme (Attending Physician):***

_____*(signature)*_____
(PRINTED NAME of MD)

## Annex C. Flowchart and Subsequent Steps in Nutrition Care Algorithm

### Nutrition Care Algorithm

(Adapted from *Standards for Specialized Nutrition Support: Adult Hospitalized Patients by Ukleja A, et al.; 2010*)




### Subsequent Steps in Nutrition Care Algorithm

| Step | Person Responsible | Expected Time of Completion | Tools Needed *(Annexes A1/A2, B, D)* |
|---|---|---|---|
| 1. Nutrition screening | Nurse | Upon admission (24 hours) | Nutrition Screening and Referral Tool *(A1/A2)* |
| 2. Referral for nutritionally-at-risk patients to RNDs | Attending physician | Upon screening | Nutrition Screening and Referral Tool *(A1/A2)* |
| 3. Nutrition assessment[a] and nutrition diagnosis[b] | RND | 24 hours upon referral | MNT Form (Nutrition Care Plan) (B) |
| 4. Dialogue with Attending Physician regarding Nutrition Care Plan | RND | As soon as possible | Patient's Form |
| 5. Conformation of NCP recommendations | Attending Physician | Immediately | MNT Form (Nutrition Care Plan)* (B) |
| 6. Implementation of the agreed nutrition intervention plan[c] | RND | Immediately | MNT Form (Nutrition Care Plan) (B) |
| 7. Nutrition monitoring and evaluation[d] | RND | As needed | MNT Form (Nutrition Care Plan) (B) |
| 8. Documentation of approved NCP and notifications to other RNDs | RND | Immediately | Patient's chart |

**shall be duly signed by the attending physician and RND to attest that there is conformation*

a. **Nutrition assessment** is the the systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is an on-going dynamic process involving not only initial data collection, but also continual reassessment and analysis of patient/client/group needs.

b. **Nutrition diagnosis** is the identification and labelling of actual occurrence, risk of, or potential for developing a nutrition problem that RND are treating independently.

c. **Nutrition interventions** are purposely-planned actions designed with the intent of changing a nutrition-related behavior, risk factors, environmental conditions or aspects of health status for an individual, a target group, or population-at large.

d. **Nutrition monitoring and evaluation** uses selected outcome indicators (markers) that are relevant to the patient's defined needs, nutrition diagnosis, nutrition goals, and disease state.

*Annex D*

# NUTRITION CARE PROCESS (NCP) BI-ANNUAL REPORT

Name of Hospital:_____Type & Level of Hospital*:_____

Reporting Period: ___ January-June ___ July-December _____ Year

| Metrics | 0-4 | | 5-9 | | 10-14 | | 15-18 | | 19-29 | | 30-39 | | 40-59 | | 60 & above | | Subtotal | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | M | F | |
| Number of patients admitted | | | | | | | | | | | | | | | | | | | |
| Number of nutritionally-at-risk (NAR) patients | | | | | | | | | | | | | | | | | | | |
| a. Wasting | | | | | | | | | | | | | | | | | | | |
| i. Moderate acute malnutrition | | | | | | | | | | | | | | | | | | | |
| ii. Severe acute malnutrition | | | | | | | | | | | | | | | | | | | |
| b. Stunting | | | | | | | | | | | | | | | | | | | |
| c. Underweight | | | | | | | | | | | | | | | | | | | |
| d. Overweight | | | | | | | | | | | | | | | | | | | |
| e. Obese | | | | | | | | | | | | | | | | | | | |
| f. Disease and other co-morbidities *(Please specify)* | | | | | | | | | | | | | | | | | | | |
| i. | | | | | | | | | | | | | | | | | | | |
| ii. | | | | | | | | | | | | | | | | | | | |
| iii. | | | | | | | | | | | | | | | | | | | |
| iv. | | | | | | | | | | | | | | | | | | | |
| Number of NAR patients given nutrition screening by the nurse | | | | | | | | | | | | | | | | | | | |
| Number of patients given nutrition assessment | | | | | | | | | | | | | | | | | | | |
| Number of patients given nutrition intervention | | | | | | | | | | | | | | | | | | | |
| Number of patients with nutrition documentation | | | | | | | | | | | | | | | | | | | |
| Number of patients given nutrition care process (ADIME) | | | | | | | | | | | | | | | | | | | |

**Public or private hospital. If public, please specify if under the management of DOH, LGU, military, SUC, etc.*

*Prepared by:*

(signature)
PRINTED NAME OF RND
Position and/or designation
Facility Name

*Noted by:*

(signature)
PRINTED NAME OF HHIMS Head
Position and/or designation
Facility Name

*Approved by:*

(signature)
PRINTED NAME OF HEAD OF FACILITY
Position
Facility Name