



Haven Hospice

Nutritional Screening Questionnaire

(To be completed on initial visit)

Patient Name:

MR#:

Date:

1. Does the patient show any signs or symptoms of Nutritional Deficit?

Recent Weight Loss

Recent Weight Gain

Loss of Appetite

Significant Knowledge Deficit re: Dietary Regimen

Patient on Medically Prescribed Diet

Patient with nutrition related problems or need

Patients with Open Wounds

Elderly patients who live alone with no support

Patients whose enteral feedings increase or decrease

Yes	No

2. Is Nutritional Screening Recommended?

Signature: _____

Comments:

Signature & Title:

Date: