ALL WALKS OF LIFE, LLC

PATIENT NAME: _____ **MR#:** _____

NUTRITIONAL SCREEN

What has your child had to eat in the past 24 hours?_____

_____

_____

Weight (of ≥ 5% over past 30 days): Stable_____ Loss_____ Gain_____

Is there any history of an eating disorder? Yes_____ No_____

If yes, explain:_____

_____

Food/Drug Allergies:_____

Please circle the appropriate response to each item:

	No Problems	Occasional Problem	Frequent/Daily Problem
Eats fewer than 2 meals per day			
Eats few fruits, vegetable, or milk products	0	1	2
Has tooth or mouth problems that make it hard to eat	0	1	2
Eats alone most of the time	0	1	2
Complains of being thirsty all the time	0	1	2

Gastrointestinal Problems:

Chronic Diarrhea	0	1	2
Constipation	0	1	2
Nausea / Vomiting	0	1	2
Frequent Reflux / Indigestion	0	1	2
Hx. Non-compliance with therapeutic diet (If yes, Score 2)			2
Current Eating disorder (If yes, Score 2)			2
Knowledge Deficit of therapeutic diet and / or needs, or patient requires further nutritional education (If yes, Score 2)			2

Appetite:

Good (Score 0)			
Fair (Score 1)			
Poor (Score 2)			

TOTAL SCORE: ADD ALL SCORES

Score: 0 & 1's only = No further action

Any 2's = Refer to nutritionist or to physician for further evaluation. (Document referral in Progress Notes.)

CARE	ASSESSMENT	WHAT TO DO:
0- 4	Low Nutritional Risk	Reassess if other issues arise
5-10	Moderate Nutritional Risk	The goal for Patients at moderate risk is to improve eating habits and lifestyle through Patient and/or caregiver education and referrals. Recheck the nutrition score in 30 days.
11 or more	High Nutritional Risk	Refer Patient and/or guardian for a Nutritional Consultation with PCP.

Date of referral to Nutritionist or Physician: _____

Staff Signature/Date: _____

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Suicide / Harm Risk Assessment	Patient Name:

Risk of Harm: Harm includes thoughts or attempts at suicide, significant self-injury, homicide, or violence towards others.

	0	1	2	Score
Attempt of HARM in facility or other Treatment Facilities	No		Yes	
Attempt at Harm to self or others	Never	Within Life Time	Within past 7 days	
Lethality of Attempts to self or others	No attempt	Low lethality	High	
Thoughts of Harm within 24 hours to self or others	No thoughts of doing harm	Intermittent or mild thoughts of doing harm	Constant or intense thoughts of doing harm	
Plans to do Harm in facility to self or others	No		Yes	
History of Family or Friend Suicide	No	Suicide Attempt	Yes - Suicide completed	
Current Symptoms: ☐ Depression ☐ Helpless ☐ Hopeless ☐ Anhedonia ☐ Humiliation ☐ Insomnia ☐ Frustrated ☐ Impulsive ☐ Shame ☐ Angry ☐ Guilt/Shame	None Denies all symptoms	Mild Presentation Able to manage without impairment	Severe Presentation Regarding one or more Items	
Alternation in Thought Process: ☐ Hallucinations ☐ Helpless ☐ Humiliation ☐ Delusions ☐ Mind Reading ☐ Disoriented ☐ Lack of eye contact ☐ Thought Insertion ☐ Delusions of Grandeur	None Mental status stable	Mild Presentation Able to manage without impairment	Severe Presentation Regarding one or more Items	
☐ Panic Attacks ☐ Anxious/ Anxiety ☐ Agitation	None	Mild Presentation Able to manage without impairment	Severe Presentation Within Last 24 Hours	
Substance use, including alcohol, benzodiazepines, pain meds, or any other substances	None	Within Past Month	Within last 24 Hours	
Significant Loss: ☐ Family ☐ Major medical ☐ Friend diagnosis ☐ Loss of Job ☐ Financial ☐ Unemployed ☐ Recent Move ☐ Declining Health ☐ Spiritual	None	Mild Presentation Able to manage without impairment	Severe Presentation Regarding one or more Items	
Subjective Appraisal of Patient's Reliability	Reliable	Uncertain	Not reliable	
			Total Score:	

This tool is a guide to assessment of risk but cannot reliably predict who will attempt harm. Clinical judgement must be used taking into account a wide variety of factors. The risk of harm may be reduced but not eliminated.

Observation Guide in Consultation with Physician

0- 14 Low risk – No action to taken at this time

15-20 Moderate risk – Continue to evaluate

21-26 High risk – Contact physician

Contact of Physician / Time / Date / Outcome: _____

_____

Staff Signature: _____ Date: _____

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PREVENTATIVE RISK REDUCTION FACTORS ASSESSMENT

The following Preventative Risk Reduction factors may be considered in the Suicide Risk Assessment to determine if at immediate/imminent danger to self by the physician. Please report all risk reduction factors to the physician if the Patientscores an eight or higher.

PREVENTATIVE RISK REDUCTION FACTORS

❒Pregnancy
❒Responsible for children under 18 years old
❒Sense of responsibility to family
❒Catholicism or Judaism is religion of choice
❒Employed
❒Living with another person, especially a relative
❒Positive social support
❒Positive therapeutic relationship
❒Restricted access to highly lethal means of suicide
❒Strong connections to family and community support
❒Skills in problem solving, conflict resolution and nonviolent handling of disputes
❒Cultural and religious beliefs that discourage suicide and support self preservation

Will any of factors reduce the Patient 's risk? ❒Yes ❒ No

Which factors & Why? _____

Does patient require re-assessment? Yes ❒ No ❒ When? _____
(Please be specific as to when (15 days, 30 days, etc)

No Harm Contract Completed: ❒Yes ❒ No

Assessment of Suicide Risk:

_____

_____

_____

Staff Signature: _____ Date: _____