the Aliveness project

Medical Nutrition Therapy (MNT)

Steps to initiate a referral for MNT:

1. Complete Aliveness membership application *(if not yet a member)*
2. Complete attached forms (see checklist below)
3. Submit forms via fax (612-822-9668) or *secure* e-mail (laurah@aliveness.org)

Forms checklist:

- ◊ Aliveness member application* (if not yet a member)
- ◊ Referral form (1 page)
- ◊ Screening form (2 pages)
- ◊ Signed and dated ROI (Aliveness ↔ Case Management Agency)
- ◊ Signed and dated ROI (Aliveness ↔ HIV Clinic)

* http://aliveness.org/wp-content/uploads/2017/10/Aliveness-Membership-Application2017.pdf

Follow up from the dietitian will be based on level of nutritional risk:

High risk: Client contacted by the RD within 1 week & followed every 1-3 months
Moderate risk: Client contacted by the RD within 2 weeks & followed at least semi-annually
Low risk: Client contacted by the RD within a month and followed at least annually

TIPS:

⇒ The individual submitting this referral should be knowledgeable of the patient's current medical condition, have access to the client's medical record, and have recently met with the client.

⇒ Portions of the screen may be done by or with other providers involved in the client's care and/or the client themselves.

⇒ The client's care team is encouraged to respond promptly to any requests for additional information for timely initiation of the MNT process.

⇒ Store a copy of these forms in the client's case management chart or medical chart.

Referral for Medical Nutrition Therapy (MNT)

Client Name: _____Date of Birth: _____

Aliveness member number (if known): _____

Contact Information (Phone/Email): _____

Okay to leave a voicemail? YES or NO

Name of HIV care provider and clinic: _____

Date of last HIV appointment:_____

Date of next HIV appointment, if scheduled: _____

AbsCD4: _____Date taken: _____VL: _____ Date taken: _____

Primary reason(s) for MNT referral:
- ☐ Mom's Meals
- ☐ Liquid supplement (e.g. Ensure)
- ☐ Other _____

Preferred pharmacy: _____ Phone: _____

Case Manager: _____ Phone: _____

Name of referring provider (if not case manager listed above): _____

Today's date: _____

For internal use:

Date referral received by RD: _____

Positive screen for FI: NO YES (Follow-up action taken: _____)

Date of 1st attempt to contact client: _____ Date of 2nd attempt to contact client: _____

Notes: _____

_____

_____

Medical Nutrition Therapy (MNT) Screening Form

Information about the client's health picture is necessary to initiate MNT. Below is a list of information commonly needed for nutrition assessment. Please fill out to the best of your ability, and don't forget signed ROI from clinic!

Food/Nutrition-Related History

Diet order/instruction (if applicable)_____

Medications (dose, frequency) ***(May attach list)*** _____

_____

_____

Dietary/herbal supplements_____

Physical Activity Restrictions: None: _____ Limit to: _____

How often are the following statements true? (circle one)			
Within the past 12 months I worried whether our food would run out before we got money to buy more.	Often	Sometimes	Never
Within the past 12 months the food I bought just didn't last and I didn't have money to get more.	Often	Sometimes	Never
Within the past 12 months I was unable to access enough food due to decreased mobility (lack of transportation, homebound, etc.)	Often	Sometimes	Never

Anthropometric Measurements (ADULTS)

Height _____ □ Measured □ Stated Weight (lb or kg) _____ □ Measured □ Stated

Usual Body Weight (UBW)_____

Target Weight _____ Ever at target weight? *NO or YES (year_____)*

Weight change (lb/kg) ↑ _____ ↓ _____ In what timeframe _____

☐ Intentional ☐ Unintentional ☐ Gestational

Biochemical Data, Medical Tests and Procedures

Please attach most current dated lab data *available including but not limited to:*

o HIV-related labs (absCD4, VL)
o Vital signs
o Electrolyte and renal profile
o Gastrointestinal profile (LFTs, etc.)
o Glucose/endocrine profile
o Inflammatory profile
o Mineral profile
o Nutritional anemia profile
o Protein profile
o Urine profile
o Vitamin profile

Nutrition-focused Physical Findings

Subjective notes on overall appearance, including any characteristics associated with pathophysiological states:

_____

_____

Client History

Medical/health history:

HIV and/or AIDS diagnosis and dates: _____

Current/recent opportunistic infections/acute illness: _____

Wasting diagnosis? YES NO

Co-morbidities (circle all that apply):

Diabetes	Cancer (type _____)
Kidney disease *(on dialysis? YES NO)*	Liver disease (ex: hepatitis C)
Cardiovascular disease (CVD)	Osteoporosis/bone disease
High blood pressure	Anemia (low iron status)
High cholesterol or triglycerides	Other _____

Other medical diagnoses and/or conditions (e.g., pregnancy): _____

Gastrointestinal/Oral problems (circle all that apply):

Nausea or Vomiting	Difficulty chewing
Frequent/chronic diarrhea	Difficulty swallowing
Constipation	Other _____
Poor Appetite	

Heartburn or GERD *(painful, burning feeling in **chest** that radiates toward the neck/back)*

Indigestion *(uncomfortable fullness during or after a meal, and burning or pain in the upper **abdomen**)*

Other (socio-cultural information (e.g. primary language if not English), health literacy, best times to contact, etc.):

_____

_____

_____

Today's date: _____

Print name of person completing this form: _____

Signature of person completing this form: _____

Relationship to client: ☐ CASE MANAGER ☐ HEALTHCARE PROVIDER ☐ SELF ☐ OTHER _____