High Risk Nutrition Care Plan: *Infants/Children*

Date: _____ Client: _____

Parent/Guardian: _____ DOB: _____ Age: _____

Physician: _____ Referral Agency: _____

PHN: _____ Case Manager: _____

Reason for Referral:_____

Subjective

Appetite: ❑ Good ❑ Fair ❑ Poor

GI complaints: ❑ Yes ❑ No If yes, check all that apply: ❑ Diarrhea ❑ Nausea ❑ Constipation ❑ Vomiting ❑ Other _____

Weight history: _____

Feeding concerns: ❑ Yes ❑ No Describe: _____

Parent/Guardian concerns: _____

Health and Social Service program participation: ❑ WIC ❑ Food Stamps ❑ Medicaid ❑ ILP ❑ HCP-CSHCN ❑ ATAP ❑ Healthy Families ❑ Other:

Objective

Gestational age _____ Birthweight _____ Length/Height _____ %tile

Length/Height ____ %tile Head Circumference ____ %tile Weight/Height _____ %tile

Laboratory Values: Hemoglobin: _____ Other: _____

Medications: ❑ Yes ❑ No If yes, list: _____

Drug/Nutrient Interaction: _____

Vitamin/Mineral Supplements: ❑ Yes ❑ No Type: _____

Assessment

Growth:_____

Feeding Skills: _____

Feeding Behavior: _____

Plan (developed by client and provider)

1. Guardian Desired Outcomes: _____
2. Education Provided: _____
3. Action Plan: _____
4. Referrals: _____
5. Follow-up Needed? ❑ Yes ❑ No Reason for Follow-up: _____
   Date of Follow-up: _____

Signature: _____ Date: _____ Phone Number: _____