High Risk Nutrition Care Plan: *Women*

Date: _____ Client: _____

Physician: _____ DOB: _____ Age: _____

PHN: _____ Referral Agency: _____

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 _____

Concerns regarding weight and weight gain? ❑ Yes ❑ No Describe: _____

_____

Client Concerns: _____

Usual food intake: _____

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

Objective

Prepregnancy Weight _____ Height _____ Weight gain _____ Weeks gestation _____ Due date _____

Laboratory Values: Hemoglobin: _____ Other: _____

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

Drug/Nutrient Interaction: _____

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

Assessment

Diet: _____

Laboratory: _____

Weight Gain: _____

Plan (developed by client and provider)

1. Client 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: _____