

Please mark the correct boxes that apply to the patient



INTENSIVE CARE UNIT SHEET 4a

Date

Center-Code

Unit-Code

Patient number

Patient Initials

NUTRITIONAL STATUS AND TREATMENT (Actual day)

Which lines and tubes does the patient have?

- | | |
|---|--|
| <input type="checkbox"/> Central venous | <input type="checkbox"/> Percutaneous endosc. Gastrostomy |
| <input type="checkbox"/> Nasogastric | <input type="checkbox"/> Percutaneous endoscopy/surgical jejunostomy (PEJ) |
| <input type="checkbox"/> Nasojejunal | <input type="checkbox"/> Periphervenous |

Nutritional approaches

- Oral Enteral Parenteral No nutrition

Number of days of parenteral feeding on ICU days (= actual date - date of the first day of parenteral or enteral nutrition given)

Number of days of enteral feeding on ICU days

Duration of enteral nutrition (within the last 24 h) hours Intermittent Continuous

Reasons for interrupting nutritional support

- Surgery Transport Intolerance Other

Calories planned per kg for the next 24 hours kcal/kg/day

Or: <500 kcal/day 500-999 kcal/day 1000-1499 kcal/day 1500-2000 kcal/day >2000 kcal/day

Gastric reflux ml Constipation or diarrhea Constipation > 3days Diarrhea

Intra abdominal pressure measured No Yes mmHg

Is feeding orally possible? No Yes

If yes, please tick: Drinking Eating

If "NO", why not?

- Patient is sedated Not allowed to eat Cannot swallow Recent aspiration

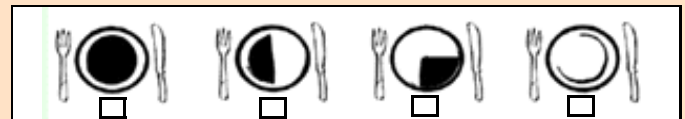
If "YES", does the patient eat...

- Normal hospital food Supplements Just drinks

ORAL NUTRITION - Please indicate for one meal:

about all 1/2 1/4 nothing

This meal was: Lunch Dinner



Ask your patient about feeling and wellbeing

- | | | | |
|-------------------------------------|---------------------------|--------------------------|-------------------------------------|
| 1. Are you hungry? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not available |
| 2. Would you like to eat something? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not available |
| 3. Are you thirsty? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not available |
| 4. Do you have a dry mouth? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not available |
| 5. Do you feel nausea? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not available |
| 6. Do you have abdominal pain? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Not available |

Please continue with sheet 4b

Please mark the correct boxes that apply to the patient



INTENSIVE CARE UNIT SHEET 4b

Date
Center-Code
Unit-Code

Patient number

Patient Initials

ENTERAL / PARENTERAL NUTRITION

Does the patient get an industrial finished product? YES No

ENTERAL nutrition product and volume [15]

Name: CODE:
This product has kcal/ml **OR in kcal**
Planned for the last 24 hours: ml/24h kcal/24h
Given within the last 24 hours: ml/24h kcal/24h

PARENTERAL nutrition product and volume

Name: CODE:
This product has kcal/ml **OR in kcal**
Planned for the last 24 hours: ml/24h kcal/24h
Given within the last 24 hours: ml/24h kcal/24h

Other nutrition product and volume

Name: CODE:
This product has kcal/ml **OR in kcal**
Planned for the last 24 hours: ml/24h kcal/24h
Given within the last 24 hours: ml/24h kcal/24h

Individually composed products/additional

if you use individually composed products, please fill in:

AMINOACIDS: amount planned for the last 24 hours: g/24h
Amount given within the last 24 hours: g/24h

CARBOHYDRATES: amount planned for the last 24 hours: g/24h
Amount given within the last 24 hours: g/24h

LIPIDS: amount planned for the last 24 hours: g/24h
Amount given within the last 24 hours: g/24h

Additional nutrients?

- Amino acids
- Glutamine
- MUFA
- Omega-3-fatty acids
- Glucose
- Vitamine E
- Selen

THANK YOU!