Please mark the correct boxes that apply to your unit

nutritionDay worldwide

UNIT SHEET
SHEET 1a

Date | | | | | | | | |
Center-Code | | | | | |
Unit-Code | | | | | |

1. Main specialty (choose only one)

- ○ Internal Medicine / General
- ○ Internal Medicine / Cardiology
- ○ Internal Medicine / Gastroenterology && hepatology
- ○ Internal Medicine / Geriatrics
- ○ Internal Medicine / Infectious diseases
- ○ Internal Medicine / Nephrology
- ○ Internal Medicine / Oncology (incl. radiotherapy)
- ○ Interdisciplinary
- ○ Long term care
- ○ Neurology
- ○ Surgery / General
- ○ Surgery/ Cardiac/Vascular/Thoracic
- ○ Surgery / Neurosurgery
- ○ Surgery / Orthopedic
- ○ Trauma
- ○ Ear Nose Throat (ENT)
- ○ Gynecology / Obstetrics
- ○ Pediatrics
- ○ Psychiatry
- ○ Others

2. Number of registered inpatients at noon | | | |

3. Total bed capacity of the unit | | | |

4. Number of each type of staff in the unit for TODAY's morning shift (excluding cleaning and temporary nDay staff)

	Fully trained	In training
Medical doctors		
Medical students	NA	
Nurses		
Nursing aides		
Dieticians		
Nutritionists		
Administrative staff		NA
Other staff involved in patient care		

5. Is there a nutrition support team in your hospital available? ○ Yes ○ No

6. Does the unit have a nutrition care strategy? ○ Yes ○ No

7. Is there a person in your unit responsible for nutrition care? ○ Yes ○ No

8. Is there a dietician, nutritionist or dietetic assistant available for your unit? ○ Yes ○ No

9. Is specific staff responsible for providing feeding assistance to patients during meal times? ○ Yes ○ No

10. How do you MAINLY screen/monitor patients for malnutrition? (choose only one answer per column)

At admission

- ○ No routine screening
- ○ No fixed criteria
- ○ Experience / visual assessment only
- ○ Weighing / BMI only
- ○ Nutritional Risk Screening (NRS) 2002
- ○ Malnutrition Universal Screening Tool (MUST)
- ○ Malnutrition Screening tool (MST)
- ○ SNAQ
- ○ Other formal tool

Please specify:

During hospital stay

- ○ No routine monitoring
- ○ No fixed criteria
- ○ Experience / visual assessment only
- ○ Weighing / BMI only
- ○ Other formal tool

Please specify:

Please continue with sheet 1b

Please mark the correct boxes that apply to your unit

nutritionDay worldwide

UNIT SHEET
SHEET 1b

Date | | | | | | | | |
Center-Code | | | | | |
Unit-Code | | | | | |

11a. Do you routinely use guidelines or standards for nutrition care? ○ Yes ○ No

11b. If yes, which one is mainly used?

- ○ International guidelines
- ○ National guidelines
- ○ Standards on hospital level
- ○ Standards on unit level
- ○ Individual patient nutrition care plans
- ○ Other

12. What is routinely done in your unit for given patient groups? (mark all that apply)

Watchful waiting	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Discuss nutrition care activities during ward rounds	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Develop an individual nutrition care plan	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Initiate treatment / nutrition intervention	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Consult a nutrition expert (dietician, nutritionist, etc.)	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Consult a medical professional	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Calculate energy requirements	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never
Calculate protein requirements	☐ At risk	☐ Malnourished	☐ Every patient	☐ Never

13. When do you routinely weigh your patients? (mark all that apply)

- ☐ at admission
- ☐ Within 24 hours
- ☐ Within 48 hours
- ☐ Within 72 hours
- ☐ Every week
- ☐ Occasionally
- ☐ When requested
- ☐ At discharge
- ☐ Never

14. What do you do to support adequate food intake of patients? (mark all that apply)

- ☐ Offer additional meals or in between snacks
- ☐ Offer meal choices
- ☐ Offer different portion sizes
- ☐ Consider food presentation
- ☐ Change food texture/consistency as needed
- ☐ Consider patient problems with eating and drinking
- ☐ Ensure that mealtimes are undisturbed/protected mealtime policy
- ☐ Promote positive eating environment
- ☐ Consider cultural/religious preferences
- ☐ Consider patient allergies / intolerances
- ☐ Other

15. Which nutrition-related standards or routine activities exist in your unit? (mark all that apply)

- ☐ Nutrition training is available
- ☐ Reporting of nutrition related information to hospital managers
- ☐ Quality indicators are recorded and reported to national or regional level
- ☐ Quality indicators are used for internal benchmarking
- ☐ Patient feedback about food and food service is collected using a questionnaire

16. At admission what is asked and documented? (mark all that apply)

- ☐ Change in weight
- ☐ Eating habits/difficulties
- ☐ Nutrition before admission

17. On what forms is there a specific part about eating, nutrition or malnutrition? (mark all that apply)

a. Patient Record has a section for ...

- ☐ indicating if the patient is malnourished or at risk of malnutrition
- ☐ nutrition treatment

b. Discharge Letter ...

- ☐ summarizes nutrition treatment received during stay
- ☐ makes future nutrition-related recommendations

18. Do you provide brochures about malnutrition to at risk/malnourished patients? ○ Yes ○ No

19. Who filled in this sheet? (mark all that apply)

- ☐ Head staff
- ☐ Dietician
- ☐ Nurse
- ☐ Physician
- ☐ Administrative staff
- ☐ Other

THANK YOU!

Please mark the correct boxes that apply to your hospital

nutritionDay worldwide

HOSPITAL SHEET

Date | | | | | | | | |

Center-Code | | | | | |

Unit-Code | | | | | |

1. Total number of beds in hospital | | | | |

2. Total number of admissions in the hospital last year | | | | | | |

3. Total number of staff in the hospital

	Total number	Full time equivalent
Total medical doctors		
Medical specialists		
Medical non-specialists		
Nurses		
Dieticians		
Nutritionists		
Pharmacists		
Kitchen staff		

4. Does the hospital have a nutrition care strategy? ◯ Yes ◯ No ◯ I do not know

5. Which nutrition-related standards or routine activities exist in your hospital?

- ☐ Nutrition training is available
- ☐ Nutrition steering committee is available
- ☐ Quality indicators are recorded and reported to national oder regional level
- ☐ Quality indicators are used for internal benchmarking
- ☐ Patient feedback about food and food service is collected using a questionnaire

6. Which codes are available /routinely used in your hospital for billing and reimbursement purposes?

Codes available

- ☐ Nutrition Support
  - ☐ Oral nutrition supplements
  - ☐ Parenteral nutrition
  - ☐ Enteral nutrition
  - ☐ Dietary counseling
  - ☐ Specific dietary interventions
- ☐ Screening for malnutrition
- ☐ Risk of malnutrition
- ☐ Malnutrition (in general)
- ☐ Severity of malnutrition (i.e. mild, moderate, severe)
- ☐ No information available from billing/finance/controlling

Codes routinely used

- ☐ Nutrition Support
  - ☐ Oral nutrition supplements
  - ☐ Parenteral nutrition
  - ☐ Enteral nutrition
  - ☐ Dietary counseling
  - ☐ Specific dietary interventions
- ☐ Screening for malnutrition
- ☐ Risk of malnutrition
- ☐ Malnutrition (in general)
- ☐ Severity of malnutrition (i.e. mild, moderate, severe)
- ☐ No information available from billing/finance/controlling

THANK YOU!

Please mark the correct boxes that apply to this patient

nutritionDay worldwide

ABOUT YOUR PATIENT
SHEET 2a

Date ☐☐ ☐☐ ☐☐☐☐
Center-Code ☐☐☐☐☐
Unit-Code ☐☐☐☐☐

Patient number ☐☐☐ **Patient Initials** [redacted] **Year of birth** ☐☐☐☐

Sex ○ Female ○ Male **Date of admission** ☐☐ ☐☐ ☐☐☐☐

Weight ☐☐☐ lb. ○ estimated ○ measured

Height ☐ ft. ☐ in. ○ estimated ○ measured **Patient consent** ○ Yes ○ No

PLEASE CONTINUE ONLY IF PATIENT GAVE CONSENT!

1. This hospital admission was… ○ **planned** ○ **an emergency** ○ **I do not know**

2a. Diagnosis at admission (mark all that apply)

- ☐ 0100 Infectious and parasitic diseases
- ☐ 0200 Neoplasms
- ☐ 0300 Blood and bloodforming organs and the immune mechanism
- ☐ 0400 Endocrine, nutritional and metabolic diseases
- ☐ 0500 Mental health
- ☐ 0600 Nervous system
- ☐ 0700 Eye and adnexa
- ☐ 0800 Ear and mastoid process
- ☐ 0900 Circulatory system
- ☐ 1000 Respiratory system
- ☐ 1100 Digestive system
- ☐ 1200 Skin and subcutaneous tissue
- ☐ 1300 Musculoskeletal system and connective tissue
- ☐ 1400 Genitourinary system
- ☐ 1500 Pregnancy, childbirth and the puerperium
- ☐ 1600 Conditions originating in the perinatal period
- ☐ 1700 Congenital/chromosomal abnormalities
- ☐ 1800 Symptoms, signs, abnormal clinical/lab findings
- ☐ 1900 Injury, poisoning
- ☐ 2000 External causes of morbidity and mortality (e.g. transport accidents, assaults)
- ☐ 2100 Factors influencing health status and contact with health services

2b. Main reason for admission (choose only one code from above) ☐☐☐☐

3. Which conditions/comorbidities does this patient have? (mark an answer for each)

Cardiac insufficiency	○ Yes	○ No	Diabetes	○ Yes	○ No
Myocardial infarction	○ Yes	○ No	Cancer	○ Yes	○ No
Chronic lung disease	○ Yes	○ No	Infection	○ Yes	○ No
Cerebral vascular disease	○ Yes	○ No	Dementia	○ Yes	○ No
Peripheral vascular disease	○ Yes	○ No	Major depressive disorder	○ Yes	○ No
Chronic liver disease	○ Yes	○ No	Other chronic mental disorder	○ Yes	○ No
Chronic kidney disease	○ Yes	○ No	Other chronic disease	○ Yes	○ No

4a. Previous operation during this hospital stay

○ Yes, planned ○ No
○ Yes, acute

days since operation ☐☐ days

4b. Planned operation during this hospital stay

○ Yes, today or tomorrow
○ Yes, later
○ No

5. Previous ICU admission during this hospital stay? ○ Yes ○ No

6. Is this patient terminally ill? ○ Yes ○ No ○ I do not know

7. Fluid status (TODAY) ○ Normal ○ Overloaded ○ Dehydrated ○ I do not know

8. Number of different medications planned (TODAY) **oral** ☐☐ **other** ☐☐

9. Was this patient identified as malnourished or at risk of malnutrition?

○ Malnourished ○ At risk ○ No ○ I do not know

Please continue with Sheet 2b

Please mark the correct boxes that apply to the patient

nutritionDay worldwide

ABOUT YOUR PATIENT
SHEET 2b

Date | Center-Code | Unit-Code

Patient number | **Patients Initials**

10. IV Fluids (TODAY) ☐ Electrolyte solution (NaCl, Ringers lactate, etc) ☐ 5% Glucose solution

11. Number of ONS drinks planned (TODAY)

12. Nutrition intake (TODAY) (mark an answer for each)

Regular hospital food	◯ Yes	◯ No	◯ I do not know
Fortified/enriched hospital food	◯ Yes	◯ No	◯ I do not know
Protein/energy supplement (e.g. ONS drinks)	◯ Yes	◯ No	◯ I do not know
Enteral nutrition	◯ Yes	◯ No	◯ I do not know
Parenteral nutrition	◯ Yes	◯ No	◯ I do not know
Special diet	◯ Yes	◯ No	◯ I do not know

13a. All lines and tubes (TODAY) (mark an answer for each)

Central Venous	◯ Yes	◯ No	Nasoduodenal	◯ Yes	◯ No
Peripheral venous access	◯ Yes	◯ No	Enterostoma	◯ Yes	◯ No
Nasogastric	◯ Yes	◯ No	Percutaneous endoscopy/surgical gastrostomy	◯ Yes	◯ No
Nasojejunal	◯ Yes	◯ No	Percutaneous endoscopy/surgical jejunostomy	◯ Yes	◯ No

13b. Were there complications with nutrition related lines and tubes since admission? (infections /obstructions)

◯ Yes, previously ◯ Yes, ongoing ◯ No ◯ I do not know

14. Please indicate if any of the following was done for this patient since admission (mark an answer for each)

Energy requirements were determined	◯ Yes	◯ No	◯ I do not know
Protein requirements were determined	◯ Yes	◯ No	◯ I do not know
Food/Nutrition intake was recorded in the patient record	◯ Yes	◯ No	◯ I do not know
Nutrition treatment plan was developed	◯ Yes	◯ No	◯ I do not know
Nutrition expert was consulted	◯ Yes	◯ No	◯ I do not know
Malnutrition status is recorded in the patient record	◯ Yes	◯ No	◯ I do not know

15a. Energy goal (YESTERDAY)

◯ <500 kcal
◯ 500-999 kcal
◯ 1000-1499 kcal
◯ 1500-1999 kcal
◯ >=2000 kcal
◯ Not determined
◯ I do not know

OR please insert ____ kcal/kg

15b. Energy intake (YESTERDAY)

◯ <500 kcal
◯ 500-999 kcal
◯ 1000-1499 kcal
◯ 1500-1999 kcal
◯ >=2000 kcal
◯ Not determined
◯ I do not know

OR please insert ____ kcal/kg

16. Since admission, this patient's health status has…

◯ Improved
◯ Deteriorated
◯ Remained the same
◯ This patient has just been admitted
◯ I do not know

Thank you!

Please mark the correct boxes

nutritionDay worldwide

PATIENT SHEET
SHEET 3a

Date | Center-Code | Unit-Code

Patient number | **Patients Initials**

1. What are your typical dietary habits? (mark all that apply)

- ☐ No special dietary habits
- ☐ I am vegetarian
- ☐ I adhee to a vegan diet
- ☐ I eat gluten-free diet
- ☐ I avoid added sugars
- ☐ I avoid carbohydrates
- ☐ I eat a low fat-diet
- ☐ I am lactose intolerant
- ☐ Other special diet due to intolerances/allergies
- ☐ Other

2. Where did you live before your current hospital admission?

- ○ At home
- ○ In a nursing home or other live-in facility
- ○ I was transferred from another hospital
- ○ Other

3. In general, are you able to walk?

- ○ Yes
- ○ Yes, with someone's help
- ○ Yes, independently using a cane, walker, or crutches
- ○ No, I have a wheelchair
- ○ No, I am bedridden

4. In general, how would you say your health is?

○ Very good ○ Good ○ Fair ○ Poor ○ Very poor

5. Over the last 12 months prior to your current hospital admission approximately…

… how many times have you seen a doctor? ____ times

… how many times have you been admitted to the hospital (Emergency room, any ward)? ____ times

… how many nights in total have you spent in hospital? ____ nights

6. How many different medications do you take routinely each day (prior to hospitalisation)?

- ○ 1-2
- ○ 3-5
- ○ More than 5
- ○ None
- ○ I do not know

7. Do you have health insurance?

- ○ Yes, private insurance only
- ○ Yes, public insurance only
- ○ Yes, both
- ○ No
- ○ I prefer not to answer

8. What was your weight 5 years ago? ____ lb. ○ I do not know

9a. Have you lost weight within the last 3 months?

- ○ Yes, intentionally
- ○ Yes, unintentionally
- ○ No, my weight stayed the same
- ○ No, I gained weight
- ○ I do not know

9b. If yes, how many kg did you lose? ____ lb. ○ I do not know

10. Did you know about your hospitalisation two days before admission? ○ Yes ○ No

11. Please indicate if you …

... were weighed at admission	○ Yes	○ No	○ I do not know
... were informed about your nutrition status	○ Yes	○ No	○ I do not know
... were informed about nutrition care options	○ Yes	○ No	○ I do not know
… received special nutrition care	○ Yes	○ No	○ I do not know

Please continue with Sheet 3b

Please mark the correct boxes that apply to you

nutritionDay worldwide

PATIENT SHEET
SHEET 3b

Date ☐☐ ☐☐ ☐☐☐☐
Center-Code ☐☐☐☐
Unit-Code ☐☐☐☐

Patient number ☐☐☐ **Patients Initials** ■■■

12. How well have you eaten in the week before you were admitted to the hospital?

- ○ More than normal
- ○ Normal
- ○ About 3/4 of normal
- ○ About half of normal
- ○ About a quarter to nearly nothing

13. In general, how satisfied are you with the food at the hospital?

- ○ Very satisfied
- ○ Somewhat satisfied
- ○ Neutral
- ○ Dissatisfied
- ○ Very dissatisfied
- ○ I do not know

14. Did you get any help with eating TODAY?

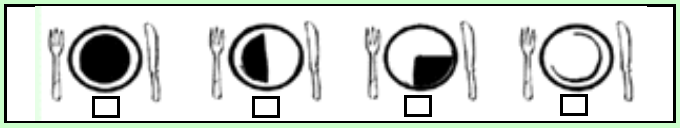
- ○ Yes, from family or friends
- ○ Yes, from hospital staff
- ○ No

15. Were you able to eat without interruption TODAY?

- ○ Yes
- ○ No

16a. Please indicate how much hospital food you ate for lunch or dinner TODAY:

about all | 1/2 | 1/4 | nothing



16b. The portion size of the meal I ordered TODAY was…

- ○ standard
- ○ smaller
- ○ larger
- ○ I do not know

17. If you did not eat everything of your meal, please tell us why: (mark all that apply)

- ☐ I did not like the type of food offered
- ☐ I did not like the smell/taste of the food
- ☐ The food did not fit my cultural/religious preferences
- ☐ The food was too hot
- ☐ The food was too cold
- ☐ Due to food allergy/intolerance
- ☐ I was not hungry at that time
- ☐ I do not have my usual appetite
- ☐ I have problems chewing/swallowing
- ☐ I normally eat less than what was served
- ☐ I had nausea/vomiting
- ☐ I was too tired
- ☐ I cannot eat without help
- ☐ I was not allowed to eat
- ☐ I had an exam, surgery, or test and missed my meal
- ☐ I did not get requested food

18. Enter the number of glasses/cups of the drinks you consumed in the last 24 hours

☐☐ Water	☐☐ Coffee	☐☐ Fruit juice	☐☐ Nutrition drink
☐☐ Tea	☐☐ Milk	☐☐ Soft drinks	☐☐ Other

19a. Did you eat any food apart from hospital food TODAY? ○ Yes ○ No

19b. If yes, what did you eat?

- ☐ Sweet snacks
- ☐ Salty snacks
- ☐ Homemade food
- ☐ Fruits
- ☐ Dairy products
- ☐ Food delivered/restaurant
- ☐ Sandwich
- ☐ Other

20. How has your food intake changed since your hospital admission?

- ○ Increased
- ○ Decreased
- ○ Stayed the same
- ○ I do not know

21. TODAY I feel…

- ○ Stronger than at admission
- ○ Weaker than at admission
- ○ Same as at admission
- ○ I was admitted today
- ○ I do not know

22. Can you walk without assistance TODAY?

- ○ Yes
- ○ No, only with assistance
- ○ No, I stay in bed

23. Did anyone help you complete this questionnaire? ○ Yes ○ No

THANK YOU!

Please mark the correct boxes that apply to this patient

nutritionDay worldwide

Center-Code | | | | | |

Unit-Code | | | | | |

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patient number | | | | **Patient Initials** [redacted] **Year of birth** | | | | |
Sex ◯ Female ◯ Male **Date of admission** | | | | | | | | |
Weight | | | | , | | kg ◯ estimated ◯ measured
Height | | | | cm ◯ estimated ◯ measured **Patient consent** ◯ Yes ◯ No

Patients list and outcomes (all ND-patients)

nutritionDay worldwide

30 days OUTCOMES

Date | | | | | | | | |

Center-Code | | | | | |

Unit-Code | | | | | |

Patient Number	Patient Initials	Discharge Date	Discharge Diagnosis			Outcome	Readmitted since ND
			(see box 1. for codes)			(see box 2. for codes)	(see box 3. for codes)
[redacted]	MA MU	24.11.2015	1. J15.212	2. G89.3	3. T45.1X5	1	1
			4. Z61.12	5.	6.		
	[redacted]						

1. Either use full ICD-10 codes or the codes below

Enter up to 6 codes, in the same order as in your records

0100 Infectious and parasitic diseases
0200 Neoplasms
0300 Blood and bloodforming organs and the immune mechanism
0400 Endocrine, nutritional and metabolic diseases
0500 Mental health
0600 Nervous system
0700 Eye and adnexa
0800 Ear and mastoid process
0900 Circulatory system
1000 Respiratory system
1100 Digestive system
1200 Skin and subcutaneous tissue
1300 Musculoskeletal system and connective tissue
1400 Genitourinary system
1500 Pregnancy, childbirth and the puerperium
1600 Conditions originating in the perinatal period
1700 Congenital/chromosomal abnormalities
1800 Symptoms, signs, abnormal clinical/lab findings
1900 Injury, poisoning
2000 External causes of morbidity and mortality (e.g. transport accidents, assaults)
2100 Factors influencing health status and contact with health services

2. Outcome Code

1= Still in the hospital
2= Transferred to another hospital
3= Transferred to long term care
4= Rehabilitation
5= Discharged home
6= Death
7= Others

3. Readmission Code

1= No
2= Yes, same hospital planned
3= Yes, same hospital unplanned
4= Yes, different hospital planned
5= Yes, different hospital unplanned
6= Unknown

THANK YOU!

 Version 1 - 07.10.2016

nutritionDay WORLDWIDE

Sheet1_oncology

Centre-code [2] ☐☐☐☐☐

Unit-code [3] ☐☐☐☐☐

Do you have a computerized documentation system in your hospital? [9]	◯ YES	◯ NO
Is nutritional treatment part of the overall care plan for oncology patients? [9]	◯ YES	◯ NO

If yes, in what way is it part of the comprehensive approach? [38]	
routinely considered	☐
when a patient asks	☐
when body weight loss > 10%	☐
during the palliative phase	☐
other, please comment	

If not, because... [10]	
lack of evidence	☐
no knowledge of the field	☐
no reimbursement	☐
it feeds the tumour	☐
other	☐

Which nutritional therapy is used for oncology patients? [10]	
nutrition according to nutrition plan	☐
calculation of energy needs	☐
monitoring patients intake and supplementation with artificial nutrition when necessary	☐
none	☐
others	☐

If not, please indicate main reasons [10]	
lack of evidence	☐
lack of experience	☐
no reimbursement	☐
lack of dietitians	☐
lack of other experts	☐
other	☐

How often do you assess the following parameters in oncology patients and which methods do you use? [39]

	regularly	at every chemotherapy	when necessary	never	?
Anthropometry / body composition					
body weight	◯	◯	◯	◯	◯
Anthropometrics (circumference)	◯	◯	◯	◯	◯
BIA	◯	◯	◯	◯	◯
CT scan	◯	◯	◯	◯	◯
DEXA	◯	◯	◯	◯	◯
other	◯	◯	◯	◯	◯
body function					
handgrip	◯	◯	◯	◯	◯
6-minutes walking test	◯	◯	◯	◯	◯
other	◯	◯	◯	◯	◯
nutritional requirements, calculated	◯	◯	◯	◯	◯
nutritional intake					
every meal	◯	◯	◯	◯	◯
1 meal per day	◯	◯	◯	◯	◯
2 meals per day	◯	◯	◯	◯	◯
24h recall	◯	◯	◯	◯	◯
other	◯	◯	◯	◯	◯

Who filled in this questionnaire (sheet 1 oncology)? [11]

◯ dietitian	◯ nurse	◯ physician	◯ nutritional scientist	◯ other

Each exponent corresponds to the numbers in the explanations

Sheet 2_oncology Sheet N° [18] ☐☐ Centre-code [2] ☐☐☐☐☐ Unit-code [3] ☐☐☐☐☐

"Unit all oncology patients"

nutritionDay WORLDWIDE

Patient ☐☐ ☐☐ (4 initials) [4]	Patient's Number [5]	Outpatient (o) / ward (w) [40]	Goal of Therapy [41]	Reason for admission [42]	Cancer diagnosis (actual) [43]	Time since cancer diagnosis [44]	Cancer Staging [45]	Time since first therapy start of actual cancer diagnosis [46]	Therapy situation [47]	Infections [48]	Lab. Parameter (CRP) only if already assessed [49]	Lab. Parameter (Albumin) only if already assessed [50]	Nutrition treatment [51]
Initials	N°	o/w	c/p/t	1-6	1-17	1-6	0-IV	1-8	1-10	1-3	○ mg/dL ○ mg/L	○ g/L ○ g/dL	1-10

GOAL OF THERAPY
- **c=** curative
- **p=** palliative
- **t=** terminal

REASON FOR ADMISSION
- **1=** clinical diagnostics
- **2=** therapy
- **3=** surgery related
- **4=** treatment complications
- **5=** poor health status
- **6=** independent care difficult

CANCER DIAGNOSIS (actual)
- **1=** breast
- **2=** colon, rectum
- **3=** prostate
- **4=** lung
- **5=** skin
- **6=** kidney/bladder
- **7=** gastric/oesophageal
- **8=** pancreas
- **9=** lymphoma
- **10=** ENT
- **11=** leukaemia
- **12=** genital tract
- **13=** liver
- **14=** sarcoma
- **15=** brain
- **16=** testicular
- **17=** other

TIME SINCE DIAGNOSIS
- **1=** 0-2 months
- **2=** 3-5 months
- **3=** 6-12 months
- **4=** 1-2 years
- **5=** 2-4 years
- **6=** > 4 years

CANCER STAGING
- **0=** carcinoma in situ
- **I=** localized
- **II=** early locally advanced
- **III=** late locally advanced
- **IV=** Metastasised

TIME SINCE FIRST THERAPY START
- **1=** no therapy
- **2=** tumour staging/diagnosis
- **3=** 0-2 months
- **4=** 3-5 months
- **5=** 6-12 months
- **6=** 1-2 years
- **7=** 2-4 years
- **8=** > 4 years

THERAPY SITUATION
- **1=** diagnosis
- **2=** chemotherapy 1st line
- **3=** chemotherapy > 1st line
- **4=** radiotherapy
- **5=** target therapy
- **6=** hormone therapy
- **7=** palliative
- **8=** surgery
- **9** = cancer related complications
- **10=** therapy related complications

INFECTIONS
- **1=** none
- **2=** local
- **3=** general

NUTRITION TREATMENT
- **1=** no special diet
- **2=** individualized diet plan
- **3=** energy rich/ protein rich ONS
- **4=** enteral nutrition (via NGT/PEG)
- **5=** parenteral nutrition
- **6=** ONS enriched with special nutrients
- **7=** special nutrients (EPA, branched chained amino acids, glutamine, arginine, carnitine)
- **8** = personal preferences
- **9** = counselling
- **10=** other

Each exponent corresponds to the numbers at the explanations

nutritionDay WORLDWIDE

Oncology Patient Sheet 3

Date [1] _ _ / _ _ / _ _ _ _

Patients number [5] ☐☐

Dear patient,
We would like you to complete this questionnaire today to optimize our nutritional care in this unit. We would like to know how you feel and how active you are.

Please check ⊗ **or fill in** m **THANK YOU FOR YOUR HELP!**

patient's-Initials: [4] first 2 letters of your first name ☐☐ first 2 letters of your last name ☐☐

Your usual body weight prior to becoming ill [52] ☐☐☐ **pounds** ◯ I do not know

Your actual weight [52] ☐☐☐ **pounds** ◯ I do not know

Was your change in weight intentionally or unintentionally? [54]

◯ intentionally ◯ unintentionally ◯ weight is stable

Please mark what best applies to you during the last week: [55]

	not at all	a little	quite a bit	very much
Have you had pain?	◯	◯	◯	◯
Did you need to rest?	◯	◯	◯	◯
Have you felt weak?	◯	◯	◯	◯
Did you feel depressed?	◯	◯	◯	◯
Were you tired?	◯	◯	◯	◯
Did pain interfere with your daily activities?	◯	◯	◯	◯
Have you lacked appetite?	◯	◯	◯	◯

Please mark what best applies to you just now: [55]

	not at all	a little	quite a bit	very much
Do you have pain?	◯	◯	◯	◯
Do you need to rest?	◯	◯	◯	◯
Do you feel weak?	◯	◯	◯	◯
Do you feel depressed?	◯	◯	◯	◯
Are you tired?	◯	◯	◯	◯
Does pain interfere with your daily activities?	◯	◯	◯	◯
Do you lack appetite?	◯	◯	◯	◯

If your appetite or food intake has changed, please indicate why? [10]

☐ nausea/vomiting ☐ constipation ☐ early satiation/ loss of appetite
☐ inflammation in mouth ☐ diarrhea
☐ pain ☐ change in taste/smell ☐ other

Which of the following activities can you perform at the maximum? (choose only one option) [56]

◯ able to do sports ◯ able to carry out self care
◯ fully active ◯ able to carry out limited self care
◯ able to carry out light activities ◯ confined to bed or chair

What do you take without prescription from a doctor? [10]

☐ nothing ☐ multivitamin
☐ herbal tea ☐ other medication
☐ nutritional supplements ☐ other

Which of the following activities do you perform? [10]

☐ nothing ☐ Meditation ☐ other
☐ Psychotherapy ☐ Progressive muscle relaxation
☐ Yoga ☐ Qigong

Is it difficult to comply with your treatment? [9] ◯ YES ◯ NO ◯ I don't know

Did anyone help you to complete the questionnaire? [9] ◯ YES ◯ NO ◯ I don't know

Do you believe that including nutrition in the therapeutic approach to your cancer could provide relevant benefit to you? [9] ◯ YES ◯ NO ◯ I don't know

Each exponent corresponds to the numbers at the explanations