**Please mark the correct boxes that apply to the patient**

nutritionDay worldwide

# 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?**

☐ Central venous
☐ Nasogastric
☐ Nasojejunal
☐ Percutaneous endosc. Gastrostomy
☐ Percutaneous endoscopy/surgical jejunostomy (PEJ)
☐ Peripheryenous

**Nutritional approaches**

☐ Oral ☐ Enteral ☐ Parenteral ☐ No nutrition

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

**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?**

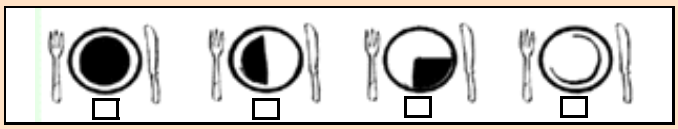
☐ Patient is sedated ☐ Not allowed to eat ☐ Cannot swallow ☐ Recent aspiration

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

☐ Normal hospital food ☐ Supplements ☐ Just drinks

**ORAL NUTRITION - Please indicate for one meal:**

**This meal was:** ○ **Lunch** ○ **Dinner**




**Ask your patient about feeling and wellbeing**

| | | | |
|---|---|---|---|
| 1. Are you hungry? | ○ Yes | ○ No | ○ Not available |
| 2. Would you like to eat something? | ○ Yes | ○ No | ○ Not available |
| 3. Are you thirsty? | ○ Yes | ○ No | ○ Not available |
| 4. Do you have a dry mouth? | ○ Yes | ○ No | ○ Not available |
| 5. Do you feel nausea? | ○ Yes | ○ No | ○ Not available |
| 6. Do you have abdominal pain? | ○ Yes | ○ No | ○ Not available |

**Please continue with sheet 4b**

**Please mark the correct boxes that apply to the patient**

nutritionDay worldwide

# 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

## Individualy composed products/additionals

**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!**