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nutritionDay in Intensive Care Unit  
Questionnaire  
SHEET 1 - UNIT INFO



Date

Center-Code

Unit-Code

1. Number of ICU beds

Current

Maximum

2. Type of ICU

☐ Medical ICU

☐ Surgical ICU

☐ Interdisciplinary ICU

☐ High Dependency Unit (HDU)

☐ Other

3. Does your ICU regularly discharge to an intermediate care unit?

☐ Yes

☐ No

☐ I don't know

4. Do you have a post-ICU clinic?

☐ Yes

☐ No

☐ I don't know

5. Do you have a regular follow-up after hospital discharge?

☐ Yes

☐ No

☐ I don't know

6. Total number of staff in the ICU

|                  | Total number | Full time equivalent |
|------------------|--------------|----------------------|
| Intensivist      |              |                      |
| Anesthesiologist |              |                      |
| Internist        |              |                      |
| Pediatrician     |              |                      |
| Surgeon          |              |                      |
| Nurse            |              |                      |
| Nursing aide     |              |                      |
| Dietician        |              |                      |
| Physiotherapist  |              |                      |
| Pharmacist       |              |                      |
| Other            |              |                      |

7. Is there a person on your unit dedicated to nutritional care?

☐ Yes

☐ No

☐ I don't know

8. Is there a nutrition team in your hospital?

☐ Yes

☐ No

☐ I don't know

9a. Do you have written procedures for nutritional care?

☐ Yes

☐ No

☐ I don't know

9b. If yes, which one:

☐ National guidelines

☐ International guidelines

☐ ICU nutrition protocol

☐ Individual patient care plans

10. How do you assess physical and nutritional status before ICU admission?

☐ Weight / Height

☐ Clinical global assessment

☐ Mobility level

☐ None

☐ Frailty level

☐ Laboratory parameters

☐ GLIM

☐ Other

11. Which parameters do you assess for physical and nutritional status in the ICU?

☐ Strength

☐ Ultrasound muscle mass

☐ CT muscle mass

☐ BIA

12. In general, what is your caloric goal on ICU day 7?

kcal/kg/day

☐ I don't know

13. In general, what is your protein goal on ICU day 7?

g/kg/day

☐ I don't know

14. How do you assess the caloric goal?

☐ Indirect Calorimetry

☐ Weight-based target

☐ Other

☐ VCO<sub>2</sub>

☐ Equation

☐ NA

15. Which body weight do you use?

☐ Actual weight

☐ Estimated weight

☐ Ideal weight

☐ Adjusted weight (ESPEN guidelines)

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Questionnaire

SHEET 2a - ABOUT YOUR PATIENT



Date       Center-Code  Unit-Code

Patient number

Date of ICU admission

Date of admission  
in hospital

Age (years)

Sex ☐ Female ☐ Male ☐ Others

Height    cm ☐ estimated ☐ measured  
Weight   kg ☐ estimated ☐ measured

(if postsurgery, please use preoperative weight)

PATIENT INFO BEFORE ICU ADMISSION:

1. Admitted to the ICU from

- ☐ Operating room  
☐ Emergency room  
☐ Other ICU  
☐ Normal ward  
☐ Other institutions  
☐ Home  
☐ Other  
☐ I don't know

2. Mobility

- ☐ Independently mobile ☐ Bedridden  
☐ Mobile with help ☐ NA

3. Did the patient have surgery?

- ☐ Scheduled surgery ☐ No surgery  
☐ Emergency surgery ☐ I don't know

days since surgery

AT ICU ADMISSION: (mark all that apply)

| (4) (5)   |   |  | (6)  |
|---|---|--|--|
| ICD-10 DIAGNOSIS  |   |  | SPECIFIC COMORBIDITIES                               |
| Nervous system  | <input type="checkbox"/> <input type="radio"/> 0600 |  | <input type="checkbox"/> Cerebral vascular disease   |
| Mental health   | <input type="checkbox"/> <input type="radio"/> 0500 |  | <input type="checkbox"/> Dementia                    |
| Eye and adnexa  | <input type="checkbox"/> <input type="radio"/> 0700 |  | <input type="checkbox"/> Major depressive disorder   |
| Ear and mastoid process   | <input type="checkbox"/> <input type="radio"/> 0800 |  | <input type="checkbox"/> Chronic mental disorder     |
| Circulatory system  | <input type="checkbox"/> <input type="radio"/> 0900 |  | <input type="checkbox"/> Myocardial infarction       |
| Respiratory system  | <input type="checkbox"/> <input type="radio"/> 1000 |  | <input type="checkbox"/> Cardiac insufficiency       |
| Endocrine, nutritional and metabolic diseases                                   | <input type="checkbox"/> <input type="radio"/> 0400 |  | <input type="checkbox"/> Chronic lung disease        |
| Digestive system  | <input type="checkbox"/> <input type="radio"/> 1100 |  | <input type="checkbox"/> Chronic liver disease       |
| Genitourinary system  | <input type="checkbox"/> <input type="radio"/> 1400 |  | <input type="checkbox"/> Chronic kidney disease      |
| Musculoskeletal system and connective tissue                                    | <input type="checkbox"/> <input type="radio"/> 1300 |  | <input type="checkbox"/> GI disease/problems         |
| Skin and subcutaneous tissue  | <input type="checkbox"/> <input type="radio"/> 1200 |  | <input type="checkbox"/> Urological disease/problems |
| Infectious and parasitic diseases   | <input type="checkbox"/> <input type="radio"/> 0100 |  | <input type="checkbox"/> Muscle-skeletal disease     |
| Neoplasms   | <input type="checkbox"/> <input type="radio"/> 0200 |  | <input type="checkbox"/> Arthritis                   |
| Blood and bloodforming organs and the immune mechanism                          | <input type="checkbox"/> <input type="radio"/> 0300 |  | <input type="checkbox"/> Skin problems               |
| Symptoms, signs, abnormal clinical/lab findings                                 | <input type="checkbox"/> <input type="radio"/> 1800 |  | <input type="checkbox"/> Peripheral vascular disease |
| External causes of morbidity and mortality (e.g. transport accidents, assaults) | <input type="checkbox"/> <input type="radio"/> 2000 |  |  |
| Pregnancy, childbirth and the puerperium  | <input type="checkbox"/> <input type="radio"/> 1500 |  |  |
| Conditions originating in the perinatal period                                  | <input type="checkbox"/> <input type="radio"/> 1600 |  |  |
| Congenital/chromosomal abnormalities  | <input type="checkbox"/> <input type="radio"/> 1700 |  |  |
| Injury, poisoning   | <input type="checkbox"/> <input type="radio"/> 1900 |  |  |
| Factors influencing health status and contact with health services              | <input type="checkbox"/> <input type="radio"/> 2100 |  |  |
| None of the above   | <input type="checkbox"/> <input type="radio"/>      |  |  |

**GENERAL COMORBIDITIES**

☐ Pain  
☐ Fatigue  
☐ Infection  
☐ Diabetes  
☐ Hypertension  
☐ Hyperlipidaemia  
☐ Endocrinal disease  
☐ Cancer (active)  
☐ History of cancer  
☐ Other chronic disease

**OTHER COMORBIDITIES**  
☐ NO COMORBIDITIES

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Date

Center-Code

Unit-Code

Patient number

### 7. Main reasons for ICU dependency at ICU admission

- |                                    |                                       |  |                                 |
|------------------------------------|---------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Cardiac      | <input type="checkbox"/> Pulmonary       | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Burns     | <input type="checkbox"/> Neurological | <input type="checkbox"/> Sepsis          | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Renal     | <input type="checkbox"/> Metabolic    | <input type="checkbox"/> Transplantation |                                 |

### 8. GLASGOW COMA SCALE (estimated score as if the patient would not be sedated)

| Eyes   | Verbal  | Motor  |
|--|---|--|
| <input type="radio"/> 1=Does not open eyes       | <input type="radio"/> 1=Makes no sounds           | <input type="radio"/> 1=Makes no movements                       |
| <input type="radio"/> 2=Opens eyes to pain       | <input type="radio"/> 2=Incomprehensible sounds   | <input type="radio"/> 2=Extension to painful stimuli             |
| <input type="radio"/> 3=Opens eyes to speech     | <input type="radio"/> 3=Utters incoherent words   | <input type="radio"/> 3=Abnormal flexion to painful stimuli      |
| <input type="radio"/> 4=Opens eyes spontaneously | <input type="radio"/> 4=Confused, disoriented     | <input type="radio"/> 4=Flexion or withdrawal to painful stimuli |
|  | <input type="radio"/> 5=Oriented, speaks normally | <input type="radio"/> 5=Localizes painful stimuli                |
|  |   | <input type="radio"/> 6=Obeys commands                           |

or provide total score of Glasgow Coma Scale

### 9. LABORATORY VALUES ON THE DAY OF ICU ADMISSION

| Value                | Unit  | MIN | MAX | Value                   | Unit   | MIN | MAX |
|----------------------|---|-----|-----|-------------------------|--|-----|-----|
| pH                   |   |     |     | WBC                     | <input type="radio"/> 10 <sup>9</sup> /μL<br><input type="radio"/> G/L |     |     |
| pCO <sub>2</sub>     | mmHg  |     |     | Platelets               | <input type="radio"/> 10 <sup>9</sup> /μL<br><input type="radio"/> G/L |     |     |
| PaO <sub>2</sub>     | mmHg  |     |     | Creatinine              | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L            |     |     |
| FiO <sub>2</sub>     |   |     |     | Serum UREA<br>OR<br>BUN | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L            |     |     |
| Lactate              | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L |     |     | Sodium                  | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L            |     |     |
| Glucose              | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L |     |     | Potassium               | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L            |     |     |
| Heart rate           | bpm   |     |     | Phosphate               | <input type="radio"/> mg/dL  |     |     |
| Syst. blood pressure | mmHg  |     |     | Bilirubin (total)       | <input type="radio"/> mg/dL<br><input type="radio"/> μmol/L            |     |     |
| Temperature          | <input type="radio"/> °C<br><input type="radio"/> °F        |     |     |                         |  |     |     |
| Urine Output         | ml/24h  |     |     |                         |  |     |     |

### 10. INFECTIONS within last 10 days:

|                         |                           |                          |                          |
|-------------------------|---------------------------|--------------------------|--------------------------|
| Pneumonia               | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |
| Urinary tract           | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |
| Vascular catheter       | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |
| Wound                   | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |
| Blood cultures positive | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |

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**Questionnaire**

**SHEET 3a - TREATMENTS TODAY**



**Date**

**Center-Code**

**Unit-Code**

**Patient number**

**1. Limitation of care**

☐ No ☐ DNR (Do Not Resuscitate) ☐ Limited care (Do Not Escalate) ☐ Comfort Terminal Care

**2. Position**

☐ Prone ☐ Supine

**3. Sedation**

☐ No ☐ Intermittent ☐ Continuous

**4. Sedation with propofol**

☐ No ☐ Yes  ml/day

**5. Neuromuscular blocker**

☐ None ☐ Intermittent ☐ Continuous

**6. Pain control**

☐ Opioids ☐ Regional pain block ☐ Other sedatives ☐ None  
☐ Epidural ☐ Alpha2-agonists ☐ Other analgetics

**RESPIRATORY**

**7. Respiratory access**

☐ Tracheostoma ☐ Oxygen mask  
☐ Endotracheal tube ☐ No  
☐ CPAP mask/helmet ☐ NA

**8. Ventilation support (more than 8 hours)**

☐ Invasive ☐ Oxygen insufflation  
☐ Non-invasive ☐ Room air  
☐ High-flow oxygen ☐ NA

**9. Does the patient have spontaneous breathing activity?**

☐ Yes ☐ No

**10. Did you perform a ventilation weaning trial on the patient?**

☐ Yes ☐ No

**11. ECMO**

☐ No ☐ Venovenous ☐ Venoarterial

**CIRCULATION**

**12. Vasoactive support (>1 hour/day)**

☐ Vasodilator ☐ Vasopressor ☐ Inotropes ☐ No

**13. Vasopressor dose**

☐ Low noradrenaline < 0.1 µg/kg/min ☐ High noradrenaline ≥ 0.1 µg/kg/min

**14. Insulin therapy**

IU/day ☐ Intermittent ☐ Continuous ☐ Pen ☐ None

**RENAL**

**15. Diuretics**

☐ None ☐ Intermittent ☐ Continuous

**16. Renal replacement therapy**

☐ Hemodiafiltration ☐ Hemodialysis ☐ No  
☐ Hemofiltration ☐ Peritoneal Dialysis

**17. IV Fluids**

☐ Crystalloid solution (NaCl, Ringers lactate, etc) ☐ Glucose solution

**18. Antibiotic treatment**

☐ Yes ☐ No ☐ I don't know

**Please continue with sheet 3b**

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SHEET 3b - TREATMENTS TODAY



Date

Center-Code

Unit-Code

Patient number

## MOBILISATION TODAY

### 19. Mobilisation level today

- |  |  |                                     |   |
|--|--|-------------------------------------|---|
| <input type="checkbox"/> Physiotherapy       | <input type="checkbox"/> In-bed cycling                | <input type="checkbox"/> Sitting    | <input type="checkbox"/> No (allowed)     |
| <input type="checkbox"/> Resistance exercise | <input type="checkbox"/> Electrical muscle stimulation | <input type="checkbox"/> Standing   | <input type="checkbox"/> No (not allowed) |
| <input type="checkbox"/> Respiratory therapy | <input type="checkbox"/> Passive range of motion       | <input type="checkbox"/> Ambulation |   |
| <input type="checkbox"/> Ergotherapy         | <input type="checkbox"/> Active moving in bed          |                                     |   |

### 20. Duration of mobilisation session

min

☐ I don't know

☐ NA

### 21. Who helped during mobilisation?

- |   |  |                                    |                                |
|---|--|------------------------------------|--------------------------------|
| <input type="checkbox"/> Nurse/Nursing aide | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Relatives | <input type="checkbox"/> Other |
|---|--|------------------------------------|--------------------------------|

### 22. Patient's reaction to mobilisation session

- |  |  |                                      |                                |
|--|--|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Higher respiratory rate | <input type="checkbox"/> Sweating    | <input type="checkbox"/> Other |
| <input type="checkbox"/> Muscular fatigue    | <input type="checkbox"/> Higher heart rate       | <input type="checkbox"/> No reaction | <input type="checkbox"/> NA    |

### 23. MRC muscle strength today: Flexion of forearm (mean of both sides)

- |   |  |
|---|--|
| <input type="radio"/> 0=no contraction                          | <input type="radio"/> 3=active movement against gravity                |
| <input type="radio"/> 1=trace of contraction but no movement    | <input type="radio"/> 4=active movement against gravity and resistance |
| <input type="radio"/> 2=active movement with gravity eliminated | <input type="radio"/> 5=normal strength                                |
|   | <input type="radio"/> It can not be evaluated                          |

## 24. LABORATORY VALUES TODAY

| Value             | Unit   | MIN | MAX |
|-------------------|--|-----|-----|
| pCO2              | mmHg   |     |     |
| PaO2              | mmHg   |     |     |
| FiO2              |  |     |     |
| ScvO2             | %  |     |     |
| Lactate           | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |
| Glucose           | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |
| Urine Output      | ml/24h   |     |     |
| WBC               | <input type="radio"/> 10 <sup>3</sup> /µL<br><input type="radio"/> G/L |     |     |
| Platelets         | <input type="radio"/> 10 <sup>3</sup> /µL<br><input type="radio"/> G/L |     |     |
| Creatinine        | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |
| Serum UREA        | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |
| OR BUN            | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |
| Potassium         | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |
| Phosphate         | <input type="radio"/> mg/dL  |     |     |
| Bilirubin (total) | <input type="radio"/> mg/dL<br><input type="radio"/> µmol/L            |     |     |

### 25. Delirium

- ☐ No  
☐ CAM-ICU positive  
☐ Suspected Delirium (CAM-ICU not performed)

### 26. RASS

- |    |  |
|----|--|
| 4  | <input type="checkbox"/> Combative         |
| 3  | <input type="checkbox"/> Very Agitated     |
| 2  | <input type="checkbox"/> Agitated          |
| 1  | <input type="checkbox"/> Restless          |
| 0  | <input type="checkbox"/> Alert and calm    |
| -1 | <input type="checkbox"/> Drowsy            |
| -2 | <input type="checkbox"/> Light Sedation    |
| -3 | <input type="checkbox"/> Moderate Sedation |
| -4 | <input type="checkbox"/> Deep Sedation     |
| -5 | <input type="checkbox"/> Unarousable       |

Please refer to the explanation sheet for more information

### 27. NEMS

- |   |   |
|---|---|
| 1 | <input type="checkbox"/> Basic monitoring                       |
| 2 | <input type="checkbox"/> Intravenous medication                 |
| 3 | <input type="checkbox"/> Mechanical ventilatory support         |
| 4 | <input type="checkbox"/> Supplementary ventilatory care         |
| 5 | <input type="checkbox"/> Single vasoactive medication           |
| 6 | <input type="checkbox"/> Multiple vasoactive medication         |
| 7 | <input type="checkbox"/> Dialysis / Hemofiltration              |
| 8 | <input type="checkbox"/> Specific interventions in the ICU      |
| 9 | <input type="checkbox"/> Specific interventions outside the ICU |

Please refer to the explanation sheet for more information

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**SHEET 4a - NUTRITIONAL TREATMENT**



Date

Center-Code

Unit-Code

Patient number

**1. Which lines and tubes does the patient have?**

- ☐ Central venous      ☐ Percutaneous endoscopic gastrostomy      ☐ Peripheral venous  
☐ Nasogastric      ☐ Percutaneous endoscopic/surgical jejunostomy (PEJ)      ☐ Pulmonary artery catheter  
☐ Nasojejunal      ☐ Peripherally inserted central catheter (PICC)      ☐ Other

**2. Nutritional approaches**

- ☐ Oral      ☐ Enteral      ☐ Parenteral      ☐ No nutrition

**3. Number of days of parenteral feeding in ICU**

days

☐ NA

**4. Number of days of enteral feeding in ICU**

days

☐ NA

**5. Duration of enteral nutrition in last 24h**

hours

☐ Intermittent

☐ Continuous

**6. Reasons for interrupting nutritional support**

- ☐ Intolerance      ☐ Transport      ☐ Other  
☐ Surgery      ☐ Testing gastric reflux      ☐ NA

**7. Calories per kg planned 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

**8. Volume of a single gastric reflux (max)**

ml

**9. Prokinetic therapy:**

- ☐ Erythromycin    ☐ Metoclopramide    ☐ No

**10. Constipation  $\geq$  3 days**

☐ Yes    ☐ No    ☐ I don't know

**11. Diarrhea**

☐ Yes    ☐ No    ☐ I don't know

**12. Vomiting**

☐ Yes    ☐ No    ☐ I don't know

**13. Intra-abdominal pressure measured**

mmHg

☐ not measured

**14a. Is oral feeding possible?**

☐ Yes    ☐ No    ☐ I don't know

**14b. If yes, what does the patient eat/drink?**

- Eating:** ☐ Normal hospital food  
☐ Mush or Yoghurt  
☐ Other  
**Drinking:** ☐ Oral nutritional supplements (ONS)  
☐ Thickened fluids  
☐ Fluids  
☐ Other

**14c. If no, why is oral feeding not possible?**

- ☐ Patient is sedated  
☐ Not allowed to eat  
☐ Cannot swallow  
☐ Recent aspiration  
☐ Problem with dental prosthesis  
☐ Other



**15. ORAL NUTRITION - Please indicate amount eaten for one chosen meal:**



about all

☐



1/2

☐



1/4

☐



nothing

☐

☐ Lunch

☐ Dinner

☐ NA

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SHEET 4b - NUTRITIONAL TREATMENT



Date       Center-Code  Unit-Code

Patient number

ENTERAL AND PARENTERAL NUTRITION

16. Does the patient receive an enteral nutrition product?

Name   Code  ☐ Yes ☐ No ☐ I don't know  
This product is ☐ industrial ☐ mixed in hospital  
This product has  kcal/L  g protein/L  
Planned for the last 24 hours  ml/24h or  kcal/24h  
Given in the last 24 hours  ml/24h or  kcal/24h

17. Does the patient receive protein powder?

g/24h ☐ No

18. Does the patient receive a parenteral nutrition product?

Name   Code  ☐ Yes ☐ No ☐ I don't know  
This product is ☐ industrial (2-in-1) ☐ industrial (3-in-1) ☐ mixed in hospital  
This product has  kcal/L  g protein/L  
Planned for the last 24 hours  ml/24h or  kcal/24h  
Given in the last 24 hours  ml/24h or  kcal/24h

19. Does the patient receives an additional nutrition product?

☐ Parenteral ☐ Enteral ☐ No

20a. Does the patient receive multivitamins?

number of vial(s)/d ☐ I don't know

b. ... trace elements?

number of vial(s)/d ☐ I don't know

c. ... vitamin B1 (thiamin)?

☐ Yes ☐ No ☐ I don't know

d. ... omega-3 fatty acids (fish oil)?

☐ Yes ☐ No ☐ I don't know

e. ... glutamine?

☐ Yes ☐ No ☐ I don't know

f. ... additional amino acids?

g/24h ☐ I don't know

21. PLEASE ASK YOUR PATIENT:

|                                     |                           |                          |                          |
|-------------------------------------|---------------------------|--------------------------|--------------------------|
| a. Are you hungry?                  | Yes                       | No                       | NA                       |
| b. Would you like to eat something? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |
| c. Are you thirsty?                 | <input type="radio"/> Yes | No                       | NA                       |
| d. Do you have a dry mouth?         | Yes                       | No                       | NA                       |
| e. Do you feel nausea?              | Yes                       | No                       | NA                       |
| f. Do you have abdominal pain?      | Yes                       | No                       | NA                       |
| g. Are you anxious?                 | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> NA |
| h. Do you feel depressed?           | Yes                       | No                       | NA                       |

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Patient name, birthdate or patient sticker  
These informations will be used by the Unit only.

|  | Patient number | Date of hospital discharge | Date of ICU discharge | Discharge Diagnosis ICU<br>(see box 1. for codes) | Outcome code<br>(see box 2. for codes) | Date of hospital readmission | Date of ICU readmission<br>within 60 days after nDay | operated after nDay ?<br>under general anaesthesia | days after surgery |
|--|----------------|----------------------------|-----------------------|---|--|------------------------------|--|--|--------------------|
|  | 123456         | dd.mm.yy                   | dd.mm.yy              | ICD-10 code                                       | code                                   | dd.mm.yy                     | dd.mm.yy   | ✓  | 1,2,3...           |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |

This information is for entry into the nutritionDay database.

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

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



Patient name, birthdate or patient sticker  
These informations will be used by the Unit only.

|  | Patient number | Date of hospital discharge | Date of ICU discharge | Discharge Diagnosis ICU<br>(see box 1. for codes) | Outcome code<br>(see box 2. for codes) | Date of hospital readmission | Date of ICU readmission<br>within 60 days after nDay | operated after nDay ?<br>under general anaesthesia | days after surgery |
|--|----------------|----------------------------|-----------------------|---|--|------------------------------|--|--|--------------------|
|  |                | dd.mm.yy                   | dd.mm.yy              |   | dd.mm.yy                               | dd.mm.yy                     | ✓  | 1,2,3...   |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |
|  |                |                            |                       |   |  |                              |  |  |                    |

This information is for entry into the nutritionDay database.