Critical Elements Only - Baseline Forms for Adults

● **= critical element**

Patient Information Form

- ● Today's date (mm/dd/year) _____
- ● ____New PN Patient ____Existing PN Patient
- ● Attending Physician's Name_____
- ● Discharging Institution Name_____
- ● PN Home Infusion Care Provider Name_____
- ● Patient Birth Date (mm/dd/yr)_____
- ● Gender: Male___ Female____
- ● Date began Home PN (mm/dd/year)_____
- ● Ethnic Category: Hispanic or Latino____ Not Hispanic or Latino____

- ● Racial Categories (select all that apply)
  - American Indian/Alaska Native___
  - Asian___
  - Native Hawaiian or Other Pacific Islander___
  - Black or African American___
  - White___
  - Other____

- ● Insurance Coverage (check all that apply)
  - Private Insurance___
  - Medicare___
  - Medicaid___
  - Personal Payment___
  - Medicare Supplement___
  - Other (Specify) _____

Baseline Nutritional Status

Baseline Nutrition Information

● Height ____ cm Length for Infants or bedbound children: ____ cm

If extrapolated, please explain and indicate method used: ____

● Usual Weight ____ Kg (prior to illness) When did the patient weigh this amount? ____ date

● Current Weight ____ Kg

● **Current Labs**

Date Labs Collected: ____ mm/dd/yr (date closest to most lab draws)

Serum Albumin ____ g/dL

Platelet Count ____ /uL (per microliter)

Direct Bilirubin ____ mg/dL

AST ____ U/L

ALT ____ U/L

INR ____

BUN ____ mg/dL

Creatinine ____ mg/dL

● **Underlying Diagnoses** (check all that apply)

- ☐ AIDS
- ☐ Esophageal Atresia
- ☐ Intestinal Atresia
- ☐ Gastroschisis
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Gastrointestinal Cancer
- ☐ Gastromotility/Pseudo-obstruction disorder
- ☐ Gynecological tumor
- ☐ Hirchsprung's Disease
- ☐ Hyperemesis Gravidarum
- ☐ Gastrointestinal Bypass for Obesity
- ☐ Mesenteric Ischemia
- ☐ Mitochondrial Disorder
- ☐ Necrotizing Enterocolitis
- ☐ Neurological Swallowing Disorder
- ☐ Non-Crohns Inflammatory Bowel Disease
- ☐ Pancreatitis/Pancreatic Insufficiency
- ☐ Short Bowel Syndrome

Small bowel stoma ○ Yes ○ No

Colonic Stoma ○ Yes ○ No

Large bowel in continuity with small bowel

○ Yes ○ No

Ileo-cecal valve present ○ Yes ○ No

Length of remaining **small** bowel in continuity ____ cm

Length of remaining **large** bowel in continuity ____ cm

Bowel measurement technique (before any lengthening procedure:

○ At time of surgery

☐ Radiation Enteritis

○ Radiographically

○ Estimated

History of bowel lengthening surgical procedure Yes____ No____

If yes, operative procedure used:

Length after lengthening surgery:

cm

☐ Other Diagnosis Please specify:

● **Reason for Parenteral Nutrition** (check all that apply)

☐ Active Inflammatory Bowel Disease

☐ Bowel dysmotility

☐ Chemotherapy Associated GI Dysfunction

☐ Congenital Bowel Defect (Intestinal Atresia)

☐ Gastrointestinal Fistula

☐ Gastrointestinal Obstruction

☐ Gastroschisis Associated Dysmotility

☐ Intractable Diarrhea

☐ Intractable Vomiting

☐ Mesenteric Ischemia

☐ Necrotizing Enterocolitis

☐ Neurological Swallowing Disorder

☐ Non-Short Bowel Diarrhea/Malabsorption

☐ Pancreatitis

☐ Radiation Enteritis

☐ Short Bowel Syndrome

☐ Other Please specify:

● **Goals of PN therapy** (check all that apply):

☐ Weight gain

☐ Weight maintenance

☐ Weight loss (for the Gastric Bypass patient with a fistula for instance)

☐ Future surgery and re-establishment of GI anatomy

☐ Indefinite (permanent) HPN

☐ Resolution of GI issue and stopping HPN

Physical Disabilities (check all that apply):

☐ Visual Impairment

☐ Hearing Deficit

☐ Dexterity Impairment

☐ Mobility Impairment

☐ Other Please specify:

Baseline PN Formula/Medication/Nutrient Intake

___ Daily

● **PN Infusion** (check each day that PN infused)

- ☐ Sunday
- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday

Total volume in ml [ ] per day or [ ] mL/kg/day

Total Dextrose in g [ ] per day or [ ] g/kg/day or Dextrose infusion rate in mg/kg/min: [ ]

Total Protein as Amino Acids in in g [ ] per day or [ ] g/kg/day

Cycled over _____ hrs

___ Daily

● **IV Fat Emulsion** (check each day that fat emulsion infused)

- ☐ Sunday
- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday

IV fat emulsion [ ] g per day or [ ] g/kg/day

- ☐ Soybean/Safflower
- ☐ Soybean only
- ☐ Emulsion containing Omega-3 fatty acids
- ☐ Other: [ ]

● **Check Medications** (Check all that apply)

- ☐ Anti-infective Agents
- ☐ Antineoplastic Agents
- ☐ Autonomic Drugs
- ☐ Cardiovascular Drugs
- ☐ Central Nervous System Agents
- ☐ Electrolytic and Water Balance (other than PN)
- ☐ Gastrointestinal Drugs (check all that apply)
  - ☐ Antacids and Adsorbents
  - ☐ Antidiarrhea Agents
  - ☐ Antiflatulents
  - ☐ Cathartics and Laxatives
  - ☐ Cholelitholytic Agents
  - ☐ Digestants
  - ☐ Emetics
  - ☐ Antiemetics
  - ☐ Lipotropic Agents
  - ☐ Antiulcer Agents and Acid Suppressants
  - ☐ Prokinetic Agents
  - ☐ Anti-inflammatory Agents
- ☐ Hormones and Synthetic Substitutes
- ☐ Pain Medications
- ☐ Vitamins (Other than PN)
- ____ Ethanol lock

● **Food/Diet** (Check all that apply)

- ☐ NPO
- ☐ On concurrent enteral nutrition

What % calories come from enteral: ☐

What type of enteral formula is the patient on? Name of product: ☐

- ☐ Liquids or oral rehydration only
- ☐ Food and/or beverages for comfort only
- ☐ Restricted/therapeutic diet
- ☐ Ad lib

If on oral nutrition, what % calories come from oral? ☐

● **Type of central venous catheter**

- ☐ PICC
- ☐ Port
- ☐ Tunneled catheter
- ☐ Other

Lumen: Single Lumen ____ Double Lumen_____ Triple Lumen____

Date of Insertion:(mm/dd/yr)_____

How often is dressing changed?(please select) Daily____, QOD____, 3 x week, Weekly

Who is changing dressings? (please select) Patient____ Caregiver_____ Both_____ Visiting Nurse____

Baseline Psychosocial –no critical elements on this form

Baseline Functional Status - no critical elements on this form