

# I. Nutrition Screen & Referral Criteria for Adults (18+ Years) with HIV/AIDS<sup>1,2</sup>

Name \_\_\_\_\_ Phone \_\_\_\_\_ Today's Date \_\_\_\_\_  
Messages:  Yes  No  Discreet

Gender \_\_\_\_\_ Language \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ File # \_\_\_\_\_

Medicaid Waiver Client?  Yes  No Insurance \_\_\_\_\_ Case Managed By \_\_\_\_\_

Referred By \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Screen every six months and/or per status change. Automatically refer to a registered dietitian for any of the following:

(Check and circle all that apply)

## A. Medical Diagnosis and Nutrition Assessment

- Newly diagnosed HIV infection
- Newly diagnosed with AIDS
- Any change in disease, diet or nutritional status
- No nutrition assessment by a registered dietitian or not seen by a registered dietitian in six months

## B. Physical Changes and Weight Concerns

- $\geq 3\%$  unintentional weight loss from usual body weight in the last 6 months or since last visit  
(% wt. loss formula:  $\frac{\text{usual body wt} - \text{current body wt}}{\text{usual body wt}} \times 100$ )
- Visible wasting,  $< 90\%$  ideal body weight,  $< 20$  BMI, or decrease in body cell mass (BCM)
- Uses anabolic steroids or growth hormone for weight, muscle gain or metabolic complications
- Lipodystrophy: lipoatrophy, central fat adiposity and/or fat accumulation on the neck, upper back, breasts or other areas
- Abdominal obesity: Waist circumference  $> 102\text{cm}$  or 40 inches (men) and  $> 88\text{cm}$  or 35 inches (women)
- Client or MD initiated weight management, or obesity:  $\text{BMI} > 30 \text{ kg/m}^2$

## C. Oral/GI Symptoms

- Uses an appetite stimulant or suppressant
- Loss of appetite, desire to eat or poor oral intake of food or fluid for  $> 3$  days
- Missing teeth, severe dental caries, difficulty chewing and/or swallowing
- Mouth sores, thrush, or mouth, tooth or gum pain
- Persistent diarrhea, constipation or change in stools (color, consistency, frequency, smell)
- Persistent nausea or vomiting
- Persistent gas, bloating or heartburn
- Changes in perception of taste or smell
- Food allergies or food intolerance's (fat, lactose, wheat, etc.)
- Medication involving food or meal modification
- Receives or needs evaluation for oral supplement or enteral or parenteral nutrition

## D. Metabolic Complications & Other Medical Conditions

- Diabetes Mellitus, impaired glucose tolerance, impaired fasting glucose, insulin resistance, or history of hypo or hyperglycemia
- Hyperlipidemia: cholesterol  $> 200\text{mg/dL}$ , triglycerides  $\geq 150\text{mg/dL}$ , LDL  $> 100\text{mg/dL}$ , and/or HDL  $< 40 \text{ mg/dL}$  (men),  $< 50 \text{ mg/dL}$  (women)
- Hypertension: two BP readings 120-139/80-90 mmHg or diagnosed with HTN
- Hepatic Disease: Hepatitis C, Hepatitis B, cirrhosis, steatosis, or other: \_\_\_\_\_
- Osteopenia/osteoporosis risk, e.g., elevated alkaline phosphatase, DEXA of the hip & spine low T-scores
- Other conditions: renal disease, anemia, heart disease, pregnancy, cancer or other: \_\_\_\_\_
- Albumin  $< 3.5 \text{ mg/dL}$ , prealbumin  $< 19 \text{ mg/dL}$ , or cholesterol  $< 120 \text{ mg/dL}$
- Scheduled chemotherapy or radiation therapy

## E. Barriers to Nutrition, Living Environment, Functional Status

Usually or always needs assistance with: Patient is:

- |   |   |   |
|---|---|---|
| 1. <input type="checkbox"/> Eating                          | 4. <input type="checkbox"/> Homebound             | 7. <input type="checkbox"/> Has limited or no cooking skills              |
| 2. <input type="checkbox"/> Preparing food                  | 5. <input type="checkbox"/> Homeless              | 8. <input type="checkbox"/> Income at or below Federal Poverty Guidelines |
| 3. <input type="checkbox"/> Shopping for food & necessities | 6. <input type="checkbox"/> Unable to secure food | 9. <input type="checkbox"/> Has no stove or refrigerator                  |

## F. Behavioral Concerns or Unusual Eating Behaviors

- Disordered eating, e.g., binges, purges, purposely skips meals, avoids eating when hungry, pica
- Alcoholic consumption:  $> 2/\text{day}$  (men),  $> 1/\text{day}$  (women), or with contraindicated condition
- Substance abuse, e.g., alcohol, tobacco, drugs
- Vegetarianism
- Client initiated vitamin and/or mineral supplementation, or complimentary or alternative diet or related therapies

1 Adapted from: Fenton M, Heller L, Vazzo L, et al. Dietitians in AIDS Care, AIDS Project Los Angeles, 1998. Nutrition screening referral criteria included in: *Guidelines for Implementing HIV/AIDS Medical Nutrition Therapy Protocols*. Approved by the Los Angeles County Commission on HIV Health Services, September 1999.

2 Adapted from the C.A.R.E. Program and Clinics - Catholic Healthcare Org., a Ryan White CARE Act Title III Grantee providing early intervention services and primary health care to people living with HIV and AIDS in Long Beach, CA; developed by Tammy Darke, RD, CNSD. Adapted by Fenton M, 5/2000, then by the ADA HIV/AIDS DPG special working groups members in 5/2002 and 3/2005.

**II. Medical Information**

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical Clinic Name: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

HIV Diagnosis Date: \_\_\_\_\_ AIDS Diagnosis:  Yes  No If yes, Date: \_\_\_\_\_

AIDS defining illnesses: \_\_\_\_\_

Other Medical Diagnosis: \_\_\_\_\_

Current Medications (dose, frequency including supplements): \_\_\_\_\_

Past Medical History: \_\_\_\_\_

Karnofsky Score: \_\_\_\_\_ Physical activity clearance:  Yes  No  Restrictions: \_\_\_\_\_

Additional Information (e.g., learning difficulties, smokes, etc.) \_\_\_\_\_

**III. Current Lab Values/Measurements**  
(Include below with date or attach recent copy)

WBC  
 RBC  
 Hgb  
 Hct  
 MCV  
 MCH  
 Sodium  
 Potassium  
 Chloride  
 Total CO2  
 BUN  
 Creatinine  
 Glucose (\_\_\_fasting \_\_\_random)  
 Fasting Insulin  
 A1c (Glycated HbA1c)

Albumin  
 Prealbumin  
 AST  
 ALT  
 Alkaline Phosphatase  
 Testosterone (total)  
 Testosterone (free)  
 Lactic Acid  
 B12  
 Folate  
 Other (\_\_\_\_\_)

**Lipids ( \_\_\_fasting \_\_\_non-fasting)**  
 Total Cholesterol  
 LDL-Cholesterol (direct/indirect)  
 HDL-Cholesterol  
 Triglycerides  
 C-reactive Protein (ultrasensitive)

**Virology/Immunology**

HIV RNA/ml  
 Highest RNA/ml (date: \_\_\_\_\_)  
 CD4  
 Nadir CD4 (date: \_\_\_\_\_)  
 Other (\_\_\_\_\_)

**Measurements**

Height (in.)  
 Weight (lbs)  
 Usual body weight (lbs)  
 Body composition result (attached)  
 DEXA hip T-score  
 DEXA spine T-score  
 Other (\_\_\_\_\_)

**IV. Physician's order for medical nutrition therapy provided by a registered dietitian****Comments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature

Date

**Physician or Individual Authorized by State to Refer for Medical Nutrition Therapy****Please note:**

**The referring agency must provide the following to the registered dietitian before appointment can be made:**

1. Nutrition Screen & Referral Criteria (I)
2. Medical Information (II)
3. Current Labs/Measurement (III)
4. Physician's order for medical nutrition therapy (IV.)
5. Signature of physician or individual authorized by the state to refer for medical nutrition therapy (IV.)
6. Signed copy of patient's consent to release medical information
7. Proof of residency and income, if required for program eligibility