

MEDICATION RECONCILIATION AND SUMMARY LIST
Nutrition and Pain Screening 204-013B back / 07-10

PATIENT LABEL

PATIENT NAME IN FULL	<input type="checkbox"/> M <input type="checkbox"/> F	AGE	MEDICAL RECORD NUMBER	DATE
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NUTRITION SCREENING	No	Yes	Score
Do you have an illness or condition that made you change the kind and/or amount of food that you eat?			2
Do you eat fewer than 2 meals per day?			3
Do you eat fruits, vegetables, or milk products less than daily?			2
Do you have 3 or more drinks of beer, liquor, or wine almost daily?			2
Do you have tooth or mouth problems that make it difficult to eat?			2
Do you lack enough money to buy the food that you need?			4
Do you eat alone most of the time?			1
Do you take 3 or more prescribed or over-the-counter medications a day?			1
Have you lost or gained 10 pounds in the last 6 months?			2
Are you sometimes unable to physically shop, cook, or feed yourself?			2
TOTAL SCORE (Add Up All Positive Responses)			
A Score of 6 or Higher Reflects Moderate to High Nutritional Risk			

PAIN SCREENING

Do you usually or always feel pain anywhere in your body? No Yes

If the Answer is No, Skip the Remainder of this Section

Can you describe where in the body the pain is located? _____

Can you describe the pain itself as: Achy Burning Dull Throbbing

On a scale of 1 to 10, with 1 being no pain and 10 being intolerable pain, how would you rate the pain you experience? _____

Are there activities or things that cause the pain or make it worse? _____

Is the pain associated with a diagnosis or condition which you understand and for which you are receiving care from another provider? No Yes

If yes, who is the provider? _____

Are you satisfied with the care from that provider? No Yes

STAFF USE ONLY

NUTRITION SCREENING

No Referral Necessary Referral to PCP as per Policy Patient Declined a Nutrition Referral

PAIN SCREENING

No Referral Necessary Referral to PCP as per Policy Patient Declined a Pain Referral

COMMENTS
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STAFF SIGNATURE	DATE
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