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
- Gastrochisis
- 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-Crohn's 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:

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
- Gastrochisis 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:

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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: [Blank] per day or [Blank] mL/kg/day

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

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

Cycled over [Blank] hrs

___ Daily

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

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

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

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