

Congestive Heart Failure (CHF)

Client Name: _____ #: _____ Initiated by: _____ Date: _____

Screen
Nutrition Screen diagnosis: CHF
Signed: _____ Date: _____

Goals (check any/all):

- Maintain or improve nutritional status in _____ (goal time).
- Eat meals/snacks without experiencing shortness of breath (SOB) in _____ (goal time).
- Perform Activities of Daily Living (ADLs) with minimal SOB in _____ (goal time).

Assess (Check any/all)
Shortness of breath (SOB) while
 Eating Performing ADLs
Weight/BMI
 BMI <20 (High Risk)
 BMI >27
 Fluctuations ≥3 - 5 lb/wk
Hydration status
 Edema 1+ 2+ 3+
 Fluid restriction
Exercise tolerance
 Fatigue Restlessness
 Medications
 Pre- or postsurgery
Poor Oral Intake Symptoms
 Complex diet order
 Nausea/vomiting
 Poor appetite/early satiety
 Problems chewing/swallowing
 Depression/anxiety
 GI distress
 Anorexia
Signed: _____ Date: _____

Moderate Risk Interventions (Check any/all)
 Food Record provided and explained
 How to read labels for sodium content explained and encouraged
Obtain Dr. orders as needed:
 RD chart consult
 Monitor weight q: _____
 BID/TID supplements
 Other: _____
(See notes for documentation.)
Signed: _____ Date: _____

High Risk Interventions (Check any/all)
 Food Record provided and explained
 How to read labels and track sodium intake stressed
Obtain Dr. orders as needed:
 RD referral for home visit(s)
 Monitor weight q: _____
 Monitor I & O q: _____
 BID/TID supplements
 Other: _____
(See notes for documentation.)
Signed: _____ Date: _____

Assess Response (Check any/all)
SOB while
 Eating Performing ADLs
 Weight fluctuations
 Exercise tolerance declining
 Fatigue increasing
Hydration status
 Edema Dehydration
 Exhibiting Poor Oral Intake Symptoms
 Other: _____
(See notes for documentation.)
Signed: _____ Date: _____

Outcomes Achieved
 SOB decreased
 Weight stabilized or improved
 Exercise tolerance maintained or improved
 Hydration status maintained or improved
 Nutritional status maintained or improved
 Other: _____
(See notes for documentation.)
 Repeat Nutrition Risk Screen in _____ days
Signed: _____ Date: _____

Assess Response (Check any/all)
SOB while
 Eating Performing ADLs
 Continued weight fluctuation
Hydration status
 Continued or increased edema
 Dehydration
 Exhibiting Poor Oral Intake Symptoms
 Other: _____
(See notes for documentation.)
Signed: _____ Date: _____

Outcomes Achieved
 SOB decreased
 Weight stabilized or improved
 Exercise tolerance maintained or improved
 Hydration status maintained or improved
 Nutritional status maintained or improved
 Other: _____
(See notes for documentation.)
 Repeat Nutrition Risk Screen in _____ days
Signed: _____ Date: _____

Outcomes Not Achieved
Reassess/evaluate need for EN/PN (refer to Tube Feeding Nutrition Care Plan). Document on Nutrition Variance Tracking form.