

Name: _____	DOB: _____
MRN: _____	

**BIRTH - 6 MONTHS**  
**ACTUAL/POTENTIAL ALTERATION IN GROWTH/NUTRITION**

Subjective:	Objective:	Assessment:	Plan/Intervention:
Parent Reports:  Healthy/stable/other _____ Appetite _____ Hunger cues _____ Feeding Skills _____ Length of feedings _____ Breast Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No How often _____ Supplements/Herbs _____ Formula Feeding _____ Formula type _____ Concentration: Cal/oz _____ Nipple type _____ Feedings at night _____ Spitting up _____ On vitamins or fluoride _____ Juice _____ oz/day Solids _____ <input type="checkbox"/> Cereal <input type="checkbox"/> Fruit <input type="checkbox"/> Vegetable <input type="checkbox"/> Eggs/meat <input type="checkbox"/> Dairy/Milk  Stool: Number of BM diapers/ day _____ Comment _____ Voids: Number of wet diapers/ day _____ Comment _____ Sleep pattern _____ Environment: <input type="checkbox"/> Calm <input type="checkbox"/> Stressed <input type="checkbox"/> Chaotic <input type="checkbox"/> Other _____ Mom's physical state: Mother reports: <input type="checkbox"/> Exhausted <input type="checkbox"/> Coping Well <input type="checkbox"/> In pain/healing <input type="checkbox"/> Depressed <input type="checkbox"/> Other _____	PCP: _____  Other Agencies Involved: <input type="checkbox"/> WIC <input type="checkbox"/> AFS <input type="checkbox"/> SCF <input type="checkbox"/> EI <input type="checkbox"/> CDRC <input type="checkbox"/> Feeding Clinic <input type="checkbox"/> Other _____ <b>Release of Info Signed: Y / N</b> Insurance _____ Age today _____ Today's weight _____ lbs Length: _____ in Head Circumference: _____ in Gain/Loss since last wt.ck. ____ Oz/day gain _____  Suck/swallow ratio _____ Length of time observed _____ State instability _____ Gastrointestinal concerns: <input type="checkbox"/> Reflux (dx) <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting <input type="checkbox"/> Retching  <b>Screening Tools:</b> <input type="checkbox"/> Feeding Assessment <input type="checkbox"/> NCAST Feeding <input type="checkbox"/> Growth Grid <input type="checkbox"/> Breastfeeding Screen (Wk 1) <input type="checkbox"/> Feeding Diary <input type="checkbox"/> S/Sx of stress <input type="checkbox"/> Sleep Activity Record  Appointments Scheduled: PCP _____ Specialist _____ WIC appointment _____	<b>Intake:</b> <input type="checkbox"/> Adequate calories <input type="checkbox"/> Inadequate calories <b>Feeding Dynamic:</b> <input type="checkbox"/> Efficient <input type="checkbox"/> Inefficient <b>Nursing Diagnosis:</b> <input type="checkbox"/> Potential/alteration: growth and development r/t _____ <input type="checkbox"/> Dysfunctional suck/swallow/ breathe r/t _____ <input type="checkbox"/> Fatigue/limited endurance r/t ____ <input type="checkbox"/> Potential/alteration: nutrition r/t ____ <input type="checkbox"/> Increased caloric need r/t _____ <input type="checkbox"/> Decreased caloric need r/t _____ <input type="checkbox"/> Potential/alteration: parenting r/t ____ <input type="checkbox"/> Potential/alteration: safety r/t _____ <input type="checkbox"/> Other _____  <b>Goals:</b> (date) _____ <input type="checkbox"/> Will gain ½ - 1oz/day by _____ <input type="checkbox"/> Will gain ____oz/week by _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Growth curve will improve by ____ <input type="checkbox"/> Coordination of care with: <input type="checkbox"/> Nutritionist <input type="checkbox"/> EI <input type="checkbox"/> PCP <input type="checkbox"/> WIC <input type="checkbox"/> Other _____ <b>Plan:</b> (date) _____ <input type="checkbox"/> Supplement with breast milk <input type="checkbox"/> Supplement with formula <input type="checkbox"/> Br feed q 1-3 hrs, minimum of 8 X's in 24hrs. <input type="checkbox"/> Add one more formula feed/day <input type="checkbox"/> Mom to keep feeding diary for: ____ days <input type="checkbox"/> Decrease supplements <input type="checkbox"/> Mom to get Elec Breast pump from WIC Other _____	<b>Instructed on:</b>  <input type="checkbox"/> Formula preparation <input type="checkbox"/> How to increase Br. Milk supply <input type="checkbox"/> How to express milk <input type="checkbox"/> Cues <input type="checkbox"/> Sleep <input type="checkbox"/> Cry <input type="checkbox"/> Hunger <input type="checkbox"/> Fullness <input type="checkbox"/> Other _____ <input type="checkbox"/> Feeding method <input type="checkbox"/> Normal suck/swallow <input type="checkbox"/> Length of feedings <input type="checkbox"/> Formula preparation <input type="checkbox"/> Bottle/nipple changes <input type="checkbox"/> Delay of solids <input type="checkbox"/> Growth and development <input type="checkbox"/> Community resources <input type="checkbox"/> Telephone _____  <b>Referrals to:</b> <input type="checkbox"/> PCP <input type="checkbox"/> Respite <input type="checkbox"/> WIC <input type="checkbox"/> Nutritionist <input type="checkbox"/> OHP <input type="checkbox"/> Mental health <input type="checkbox"/> EI <input type="checkbox"/> Food stamps <input type="checkbox"/> Lactation consultant <input type="checkbox"/> Cacoon nurse  <b>Handouts provided:</b> <input type="checkbox"/> Feeding brochure <input type="checkbox"/> Info related to diagnosis <input type="checkbox"/> Other _____  Follow up Plan, Monitoring & Advocacy: <input type="checkbox"/> Telephone _____ <input type="checkbox"/> Revisit _____ <input type="checkbox"/> Faxed report to _____ on date _____

Nurse: \_\_\_\_\_

Date: \_\_\_\_\_

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<u>Examples of charting:</u> Breastfeeding <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Describe</u> 10 min q 2 hr 50 min q 4 hr Supplements: Br milk by SNS Formula by bottle  suck/swallow ratio Describe as 10 sucks/swallow or 1 suck/1 swallow for solid 5 min  Normal formula concentration is 20 cal/oz.		WIC Mixing instructions for <u>24-kcal</u> concentration of Standard Infant Formula (with PCP order only)
		<p style="text-align: center;">POWDER</p> To get 5 oz. of formula, mix: 5 oz of water 3 scoops of formula  To get 3-3/4 oz of formula, mix: 3 ¼ oz of water (1/3 cup plus 4 tsp) 2 scoops of formula  For larger quantities mix: 15 oz water ½ cup plus 1 scoop of powder
		<p style="text-align: center;">CONCENTRATE</p> To get 5 oz of formula, mix: 2 oz of water 3 oz of concentrate To get 22 oz of formula, mix: 9 oz of water 13 oz of concentrate (1 can)

<i>Computing Growth Requirements</i>	Example with an 8 lb baby:	
Wt ÷ 2.2 = Kg	8 lb ÷ 2.2 = 3.63 kg (3.6 kg)	
Growth requirements 0-6 mo. old infant Minimum needed for growth = 110 kcal/kg in 24hrs Catch up growth = 140 kcal/kg in 24 hrs		

<i>Formulas:</i>		
<i>Minimum needed for growth:</i> 110 X wt of child in Kg ÷ # of calories/oz in formula = # of ounces needed in 24 hrs.	Example: 110 X 3.6 = 399.3 (400) 400 ÷ 20 cal/oz = 20oz 400 ÷ 24 cal/oz = 16.7oz	400 = # of calories needed in 24 hrs. 20 is the # of ounces of 20 cal/oz formula needed in 24 hrs. 16.7 is the # of ounces of 24 cal/oz formula needed in 24 hrs.
<i>Catch up Growth:</i> 140 X wt of child in Kg ÷ # of calories/oz in formula = # of ounces needed in 24 hrs.	Example: 140 X 3.6 = 508.2 (508) 508 ÷ 20 cal/oz = 25.4 508 ÷ 24 cal/oz = 21	508 = # of calories needed in 24 hrs. 25.4 = # of ounces of 20 cal formula needed in 24 hrs. 21 = # of ounces of 24 cal formula needed in 24 hrs.

	0	1	2
<b>L</b> Latch	- Too sleepy or reluctant - No latch achieved	- Repeated attempts	- Grasps breast - tongue down - Tongue down - Rhythmical sucking
<b>A</b> Audible Swallowing	- None	- A few with stimulation	- Spontaneous & intermittent - Spontaneous & frequent
<b>T</b> Type of Nipple	- Inverted	- Flat	- Everted (after stimulation)
<b>C</b> Comfort (Breast & Nipple)	- Engorged - Cracked, bleeding, lg blisters or bruises	- Filling - Reddened and blisters or bruises - Mild/Med Discomfort	- Soft - Tender
<b>H</b> Hold (Positioning)	- Full assist (Staff holds)	- Minimal assist - Teach one, mom does one	- No assist from staff - Mom able to position/hold baby