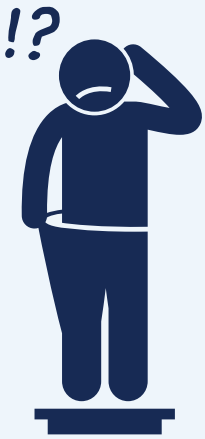
A Guide for Adults

How to Spot and Talk About Symptoms That Could Mean You're Malnourished

Poor nutrition and eating problems can put you at risk of being malnourished. Malnutrition threatens your health and your ability to recover from injuries or illnesses. That's why it is important for you to know what symptoms to look for and when you need to address them.

If you were recently hospitalized, been given directions regarding your diet, or been told you need a bit more nourishment, it is particularly important that you keep, follow, and share this information with those who care for you.



What You Need to Watch For

Since malnutrition may not be immediately apparent, you need to watch for, write down, and talk about any changes you notice in:

- Your appetite
- How much food you eat
- Your bowel habits
- Your weight
- Your daily activity levels
- Swelling in your belly, legs, ankles, and feet

You're doing OK if you can say: ***"I feel good. I eat three meals a day and have the energy to do what I want."***

When You Need to Be Concerned

If you notice any of the following warning signs, you need to discuss them with your healthcare provider:

- Sudden loss or decrease in appetite
- Eating less than 75% of a normal meal for more than a week
- Episodes of nausea, vomiting, or diarrhea for more than three days
- Unplanned weight loss greater than 10 pounds
- Decrease in activity level

Schedule an appointment if you find yourself saying: ***"I haven't wanted to eat anything since I started this new medication..." "I'm not finishing my meals like I used to..." "My stomach has been upset for days..." "My clothes don't seem to be fitting like they had been..." "I don't have any energy..."***

When You're in Danger from Malnutrition

The following are dangerous signs that you could be malnourished:

- Eating half as much as you normally do for more than a week
- Persistent nausea, vomiting, or diarrhea
- Sudden and rapid weight loss with noticeable muscle and/or fat loss
- Swelling in your feet, ankles, legs, or belly
- Feeling confused or having increased memory loss

Act immediately if you find yourself saying: ***"It's been over a week and I can hardly eat a bite..." "I can't stop going to the bathroom..." "My feet and ankles are swollen..."" I can't concentrate when my family is talking to me ..."***

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Keep Watching and Keep Talking

Don't take changes in your nutrition for granted. Be aware of what you may have been thinking or saying about how you've been eating and how you've been feeling. Share your conversations and symptoms with your healthcare provider. **Don't wait for them to ask!**

You're at the Highest Risk If...

You need to be constantly watchful for the warning signs of malnutrition if you are 85 years old or older. A number of acute or chronic diseases also put you at a much higher risk. Be sure to talk with your healthcare provider if you suffer from any of the following:

- Injury or Trauma
- Any diseases requiring multiple medications
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Kidney or Liver Disease
- Gastrointestinal Dysfunctions such as Inflammatory Bowel Disease
- Depression or Dementia

Visit the Malnutrition Solution Center

Take advantage of the valuable information and free resources that can help you, your family members and caregivers identify and understand malnutrition available at **nutritioncare.org/malnutrition.**

Here you can:

- Learn from the true-life stories of patients who've suffered from malnutrition
- Download nutrition tips and helpful posters on spotting malnutrition in children and adults
- Learn about other resources for older adults, including links to local Meals on Wheels programs

This information is adapted from a video presented by Angela Newton, MBA, RD, and the ASPEN Malnutrition Committee. The video and other resources on malnutrition can be found at ***nutritioncare.org/malnutrition.***

Tips for Proper Nutrition and Staying Healthy

Eat **three balanced meals every day** that include protein and fiber from fruits, vegetables and whole grains

Stay hydrated with fluids (8 cups per day for most adults)

Follow your **healthcare provider's or dietitian's orders** for any diet restrictions including fluids

Know your **bowel habits** (frequency and consistency)

Check your weight weekly and write it down

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Nestlé Nutrition Institute

Self-MNA®

Mini Nutritional Assessment

For Adults 65 years of Age and Older

Last name: First name:

Date: Age:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening		
A Has your food intake declined over the past 3 months? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, or 2) in the box to the right.*	0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake	
B How much weight have you lost in the past 3 months? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, 2 or 3) in the box to the right.*	0 = weight loss greater than 7 pounds 1 = do not know the amount of weight lost 2 = weight loss between 2 and 7 pounds 3 = no weight loss or weight loss less than 2 pounds	
C How would you describe your current mobility? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, or 2) in the box to the right.*	0 = unable to get out of a bed, a chair, or a wheelchair without the assistance of another person 1 = able to get out of bed or a chair, but unable to go out of my home 2 = able to leave my home	
D Have you been stressed or severely ill in the past 3 months? [ENTER ONE NUMBER] *Please enter the most appropriate number (0 or 2) in the box to the right.*	0 = yes 2 = no	
E Are you currently experiencing dementia and/or prolonged severe sadness? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, or 2) in the box to the right.*	0 = yes, severe dementia and/or prolonged severe sadness 1 = yes, mild dementia, but no prolonged severe sadness 2 = neither dementia nor prolonged severe sadness	
Please total all of the numbers you entered in the boxes for questions A-E and write the numbers here:		

Now, please CHOOSE ONE of the following two questions – F1 or F2 – to answer.

Question F1

Height (feet & inches)	**Body Weight** (pounds)			
4'10"	Less than 91	91 – 99	100 – 109	110 or more
4'11"	Less than 94	94 – 103	104 – 113	114 or more
5'0"	Less than 97	97 – 106	107 – 117	118 or more
5'1"	Less than 100	100 – 110	111 – 121	122 or more
5'2"	Less than 104	104 – 114	115 – 125	126 or more
5'3"	Less than 107	107 – 117	118 – 129	130 or more
5'4"	Less than 110	110 – 121	122 – 133	134 or more
5'5"	Less than 114	114 – 125	126 – 137	138 or more
5'6"	Less than 118	118 – 129	130 – 141	142 or more
5'7"	Less than 121	121 – 133	134 – 145	146 or more
5'8"	Less than 125	125 – 137	138 – 150	151 or more
5'9"	Less than 128	128 – 141	142 – 154	155 or more
5'10"	Less than 132	132 – 145	146 – 159	160 or more
5'11"	Less than 136	136 – 149	150 – 164	165 or more
6'0"	Less than 140	140 – 153	154 – 168	169 or more
6'1"	Less than 144	144 – 158	159 – 173	174 or more
6'2"	Less than 148	148 – 162	163 – 178	179 or more
6'3"	Less than 152	152 – 167	168 – 183	184 or more
6'4"	Less than 156	156 –171	172 – 188	189 or more
Group	**0**	**1**	**2**	**3**

Please refer to the chart on the left and follow these instructions:

1. Find your height on the left-hand column of the chart.
2. Go across that row and circle the range that your weight falls into.
3. Look to the bottom of the chart to find out what group number (0, 1, 2, or 3) your circled weight range falls into.

Write the Group Number (0, 1, 2, or 3) here: ☐

Write sum of questions A-E (from page 1) ☐

Lastly, calculate the sum of these 2 numbers. This is your SCREENING SCORE: ☐

Question F2 DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

Measure the circumference of your LEFT calf by following the instructions below:

1. Loop a tape measure all the way around your calf to measure its size.
2. Record the measurement in cm: _____
   - If less than 31cm, enter "0" in the box to the right.
   - If 31cm or greater, enter "3" in the box to the right.

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☐

Write the sum of questions A-E (from page 1) here: ☐ ☐

Lastly, calculate the sum of these 2 numbers. This is your SCREENING SCORE: ☐ ☐

Screening Score (14 points maximum)

12–14 points: Normal nutritional status

8–11 points: At risk of malnutrition

0–7 points: Malnourished

Copy your SCREENING SCORE: ☐ ☐

If you score between 0-11, please take this form to a healthcare professional for consultation.

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Nestlé NutritionInstitute

Self-MNA®

Mini Nutritional Assessment

Para adultos a partir de 65 años

Apellidos: Nombre:

Fecha: Edad:

Responda al cuestionario de cribado rellenando las casillas con los números correspondientes. Sume los números para obtener la puntuación final.

Cribado		
A ¿Ha disminuido su ingesta de alimentos en los últimos 3 meses? *Introduzca el número más adecuado (0, 1 o 2) en la casilla de la derecha.*	0 = Disminución importante de la ingesta de alimentos 1 = Disminución moderada de la ingesta de alimentos 2 = Sin disminución de la ingesta de alimentos	☐
B ¿Cuánto peso ha perdido en los últi mos 3 meses? *Introduzca el número más adecuado (0, 1, 2 o 3) en la casilla de la derecha.*	0 = He perdido más de 3 kg 1 = No sé cuánto peso he perdido 2 = He perdido entre 1 y 3 kg 3 = No he perdido peso o he perdido menos de 1 kg	☐
C ¿Cómo describiría su movilidad actual? *Introduzca el número más adecuado (0, 1 o 2) en la casilla de la derecha.*	0 = No puedo levantarme de la cama, de una silla o de la silla de ruedas sin la ayuda de otra persona 1 = Puedo levantarme de la cama o de una silla, pero no puedo salir de casa 2 = Puedo salir de casa	☐
D ¿Ha estado estresado/a o gravemente enfermo/a en los últimos 3 meses? *Introduzca el número más adecuado (0 o 2) en la casilla de la derecha.*	0 = Sí 2 = No	☐
E ¿Padece actualmente demencia o una tristeza intensa prolongada? *Introduzca el número más adecuado (0, 1 o 2) en la casilla de la derecha.*	0 = Sí, demencia grave y/o tristeza intensa prolongada 1 = Sí, demencia leve, pero sin tristeza intensa prolongada 2 = Ni demencia ni tristeza intensa prolongada	☐
Sume todos los números que ha introducido en las casillas de las preguntas A a la E y anote el resultado aquí:		☐☐

A continuación, ELIJA UNA de las siguientes preguntas, F1 o F2, y respóndala.

Pregunta F1

Estatura (cm)	**Peso** (kg)			
147.5	Menos de 41.1	41.1 – 45.3	45.4 – 49.6	49.7 o más
150	Menos de 42.8	42.8 – 47.2	47.3 – 51.7	51.8 o más
152.5	Menos de 44.2	44.2 – 48.7	48.8 – 53.4	53.5 o más
155	Menos de 45.6	45.6 – 50.4	50.5 – 55.2	55.3 o más
157.5	Menos de 47.1	47.1 – 52.0	52.1 – 57.0	57.1 o más
160	Menos de 48.6	48.6 – 53.7	53.8 – 58.8	58.9 o más
162.5	Menos de 50.2	50.2 – 55.4	55.5 – 60.6	60.7 o más
165	Menos de 51.7	51.7 – 57.1	57.2 – 62.5	62.6 o más
167.5	Menos de 53.3	53.3 – 58.8	58.9 – 64.4	64.5 o más
170	Menos de 54.9	54.9 – 60.6	60.7 – 66.4	66.5 o más
172.5	Menos de 56.5	56.5 – 62.4	62.5 – 68.3	68.4 o más
175	Menos de 58.2	58.2 – 64.2	64.3 – 70.3	70.4 o más
177.5	Menos de 59.9	59.9 – 66.1	66.2 – 72.4	72.5 o más
180	Menos de 61.6	61.6 – 67.9	68.0 – 74.4	74.5 o más
182.5	Menos de 63.3	63.3 – 69.8	69.9 – 76.5	76.6 o más
185	Menos de 65.0	65.0 – 71.8	71.9 – 78.6	78.7 o más
187.5	Menos de 66.8	66.8 – 73.7	73.8 – 80.8	80.9 o más
190	Menos de 68.6	68.6 – 75.7	75.8 – 82.9	83.0 o más
192.5	Menos de 70.4	70.4 – 77.7	77.8 – 85.1	85.2 o más
Grupo	**0**	**1**	**2**	**3**

Consulte la tabla de la izquierda y siga las instrucciones siguientes:

1. Encuentre su estatura en la columna de la izquierda de la tabla.
2. En esa misma fila rodee con un círculo el intervalo de peso en el que se encuentra.
3. Mire en la parte inferior de la tabla el número de grupo (0, 1, 2 o 3) al que corresponde el intervalo de peso que ha marcado.

Anote aquí el número de grupo (0, 1, 2 o 3): ☐

Anote aquí la suma de las preguntas A-E (de la página 1): ☐

Por último, sume estos dos números. Esta es su PUNTUACIÓN FINAL: ☐

Pregunta F2

NO RESPONDA A LA PREGUNTA F2 SI YA HA RESPONDIDO A LA PREGUNTA F1

Mida la circunferencia de su pantorrilla IZQUIERDA siguiendo las instrucciones siguientes:

1. Coloque una cinta métrica alrededor de la pantorrilla para medir su tamaño.
2. Anote la longitud en centímetros: _____
   - Si mide menos de 30 centímetros, introduzca "0" en la casilla de la derecha.
   - Si mide 30 centímetros o más, introduzca "3" en la casilla de la derecha.

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☐

Anote aquí la suma de las preguntas A-E (de la página 1): ☐☐

Por último, sume estos dos números: ☐☐

Puntuación del cuestionario (14 puntos como máximo)

12–14 puntos: Estado nutricional normal
8–11 puntos: Riesgo de desnutrición
0–7 puntos: Desnutrido

Copie su PUNTUACIÓN FINAL: ☐☐

Si la puntuación está entre 0 y 11, lleve este cuestionario a un profesional sanitario para recibir asesoramiento.

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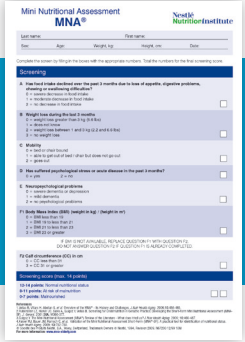
Nutrition Screening as easy as mna

A guide to completing the Mini Nutritional Assessment – Short Form (MNA®-SF)

Screen and intervene.
Nutrition can make a difference.



Mini Nutritional Assessment
MNA®

Nestlé Nutrition Institute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F1 Body Mass Index (BMI) (weight in kg) / (height in m²)
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

F BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater

Screening score (max. 14 points)

12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished

Reference:
Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-form Mini-nutritional Assessment (MNA-SF). J Gerontol A Biol Sci Med Sci. 2001; 56:M366-372.
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For more information: www.mna-elderly.com

Nestlé Nutrition Institute

Introduction

Mini Nutritional Assessment – Short Form (MNA®-SF)

The MNA®-SF is a screening tool to help identify elderly patients who are malnourished or at risk of malnutrition. This User Guide will assist you in completing the MNA®-SF accurately and consistently. It explains each question and how to assign and interpret the score.

Introduction

While the prevalence of malnutrition in the free living elderly population is relatively low, the risk of malnutrition increases dramatically in the institutionalized and hospitalized elderly.[1] The prevalence of malnutrition is even higher in cognitively impaired elderly individuals and is associated with cognitive decline.[2]

Patients who are malnourished when admitted to the hospital tend to have longer hospital stays, experience more complications, and have greater risks of morbidity and mortality than those whose nutritional state is normal.[3]

By identifying older persons who are malnourished or at risk of malnutrition either in the hospital or community setting, the MNA®-SF allows clinicians to intervene earlier to provide adequate nutritional support, prevent further deterioration, and improve patient outcomes.[4]

Mini Nutritional Assessment – Short Form (MNA®-SF)

The MNA®-SF provides a simple and quick method of identifying elderly persons who are at risk for malnutrition, or who are already malnourished. It identifies the risk of malnutrition before severe changes in weight or serum protein levels occur.

The MNA®-SF was developed by Nestlé and leading international geriatricians and remains one of the few validated screening tools for the elderly. It has been well validated in international studies in a variety of settings[5-7] and correlates with morbidity and mortality.

In 2009 the MNA®-SF was validated as a stand alone screening tool, based on the full MNA®.[8] The MNA®-SF may be completed at regular intervals in the community and in the hospital or long-term care setting. It is recommended to be done annually in the community, and every 3 months in the hospital or long-term care or whenever a change in clinical condition occurs.

Instructions to complete the MNA®-SF

Before beginning the MNA®-SF, please enter the patient's information on the top of the form:

- *Name • Gender • Age*
- *Weight (kg)* – To obtain an accurate weight, remove shoes and heavy outer clothing. Use a calibrated and reliable set of scales. Pounds (lbs) must be converted to kilograms (1 lb = 0.45 kg).
- *Height (cm)* – Measure height without shoes using a stadiometer (height gauge). If the patient is bedridden, measure height by demispan, half arm-span, or knee height (see Appendix 2). Inches must be converted to centimeters (1 inch = 2.54 cm).
- *Date of screen*

Identify

The Mini Nutritional Assessment Short Form (MNA®-SF) is an effective tool to help identify patients who are malnourished or at risk of malnutrition

✔ Most validated tool for the elderly

- Sensitive and reliable
- Recommended by national and international organisations
- Supported by more than 450 published studies

✔ Quick and easy to use

- Screen in less than 5 minutes
- Requires no special training
- No laboratory data needed

✔ Effective

- Identifies at-risk persons before weight loss occurs

✔ Facilitates early intervention

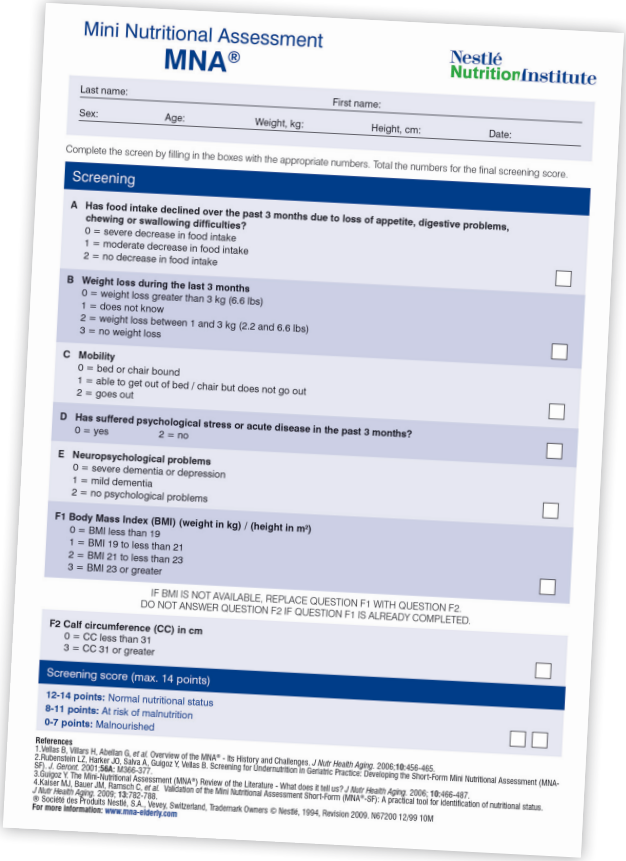
Intervene

Recommend Nestlé Nutrition supplements to help your patients improve their nutritional status

Monitor

✔ Inexpensive diagnostic tool

- The MNA®-SF tool allows standardised, reproducible and reliable determination of nutritional status
- Use the MNA®-SF regularly to assess your patients' nutritional status and provide intervention as required



Mini Nutritional Assessment
MNA®

Nestlé NutritionInstitute

Last name: First name:
Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F1 Body Mass Index (BMI) (weight in kg) / (height in m²)
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater

Screening score (max. 14 points)

12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished

References
1.Vellas B, Villars H, Abellan G, *et al.* Overview of the MNA® - Its History and Challenges. *J Nutr Health Aging.* 2006;**10**:456-465.
2.Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J. Geronol.* 2001;**56A**: M366-377.
3.Guigoz Y. The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us? *J Nutr Health Aging.* 2006; **10**:466-487.
4.Kaiser MJ, Bauer JM, Ramsch C, *et al.* Validation of the Mini Nutritional Assessment Short-Form (MNA®-SF): A practical tool for identification of nutritional status. *J Nutr Health Aging.* 2009; **13**:782-788.
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For more information: www.mna-elderly.com

Screening (MNA®-SF)

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Key Points

Ask the patient to answer questions A – F, using the suggestions in the shaded areas. If the patient is unable to answer the question, ask the patient's caregiver to answer or check the medical record.

A

Has food intake declined over the past three months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

Score 0 = Severe decrease in food intake
1 = Moderate decrease in food intake
2 = No decrease in food intake

Ask patient or caregiver or check the medical record

- *"Have you eaten less than normal over the past three months?"*
- If so, *"is this because of lack of appetite, chewing, or swallowing difficulties?"*
- If yes, *"have you eaten much less than before or only a little less?"*

B

Involuntary weight loss during the last 3 months?

Score 0 = Weight loss greater than 3 kg (6.6 pounds)
1 = Does not know
2 = Weight loss between 1 and 3 kg (2.2 and 6.6 pounds)
3 = No weight loss

Ask patient / Review medical record

- *"Have you lost any weight without trying over the last 3 months?"*
- *"Has your waistband gotten looser?"*
- *"How much weight do you think you have lost? More or less than 3 kg (or 6 pounds)?"*

Though weight loss in the overweight elderly may be appropriate, it may also be due to malnutrition. When the weight loss question is removed, the MNA® loses its sensitivity, so it is important to ask about weight loss even in the overweight.

C

Mobility?

Score 0 = Bed or chair bound

1 = Able to get out of bed/chair, but does not go out

2 = Goes out

Ask patient / Review patient's medical record / Ask caregiver

- *"How would you describe your current mobility?"*
  - *"Are you able to get out of a bed, a chair, or a wheelchair without the assistance of another person?"* – if not, would score 0
  - *"Are you able to get out of a bed or a chair, but unable to go out of your home?"* – if yes, would score 1
  - *"Are you able to leave your home?"* – if yes, would score 2

D

Has the patient suffered psychological stress or acute disease in the past three months?

Score 0 = Yes

2 = No

Ask patient / Review patient medical record / Use professional judgment

- *"Have you been stressed recently?"*
- *"Have you been severely ill recently?"*

E

Neuropsychological problems?

Score 0 = Severe dementia or depression

1 = Mild dementia

2 = No psychological problems

Review patient medical record / Use professional judgment / Ask patient, nursing staff or caregiver

- *"Do you have dementia?"*
- *"Have you had prolonged or severe sadness?"*

The patient's caregiver, nursing staff or medical record can provide information about the severity of the patient's neuropsychological problems (dementia).

F1

Body mass index (BMI)?
(weight in kg / height in m^2)

Score 0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

Determining BMI
BMI is used as an indicator of appropriate weight for height (Appendix 1)

BMI Formula – US units
- BMI = (Weight in Pounds / [Height in inches x Height in inches]) x 703

BMI Formula – Metric units
- BMI = (Weight in Kilograms / [Height in Meters x Height in Meters])

1 Pound = 0.45 Kilograms
1 Inch = 2.54 Centimeters

Before determining BMI, record the patient's weight and height on the MNA® form.

1. If height has not been measured, please measure using a stadiometer or height gauge (Refer to Appendix 2).
2. If the patient is unable to stand, measure height using indirect methods such as measuring demi-span, arm span, or knee height. (See Appendix 2).
3. Using the BMI chart provided (Appendix 1), locate the patient's height and weight and determine the BMI.
4. Fill in the appropriate box on the MNA® form to represent the BMI of the patient.
5. To determine BMI for a patient with an amputation, see Appendix 3.

**IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.**

F2 Answer only if unable to obtain BMI.

Calf circumference (CC) in cm

0 = CC less than 31

3 = CC 31 or greater

Measuring Calf Circumference

1. The subject should be sitting with the left leg hanging loosely or standing with their weight evenly distributed on both feet.
2. Ask the patient to roll up their trouser leg to uncover the calf.
3. Wrap the tape around the calf at the widest part and note the measurement.
4. Take additional measurements above and below the point to ensure that the first measurement was the largest.
5. An accurate measurement can only be obtained if the tape is at a right angle to the length of the calf.

To measure calf circumference in bed-bound elderly, please refer to Appendix 4

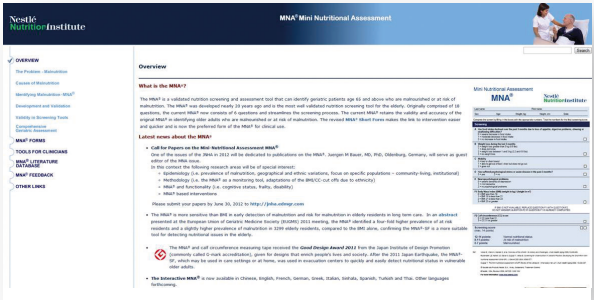
Add the numbers to obtain the screening score.

Screening Score (Max. 14 points)

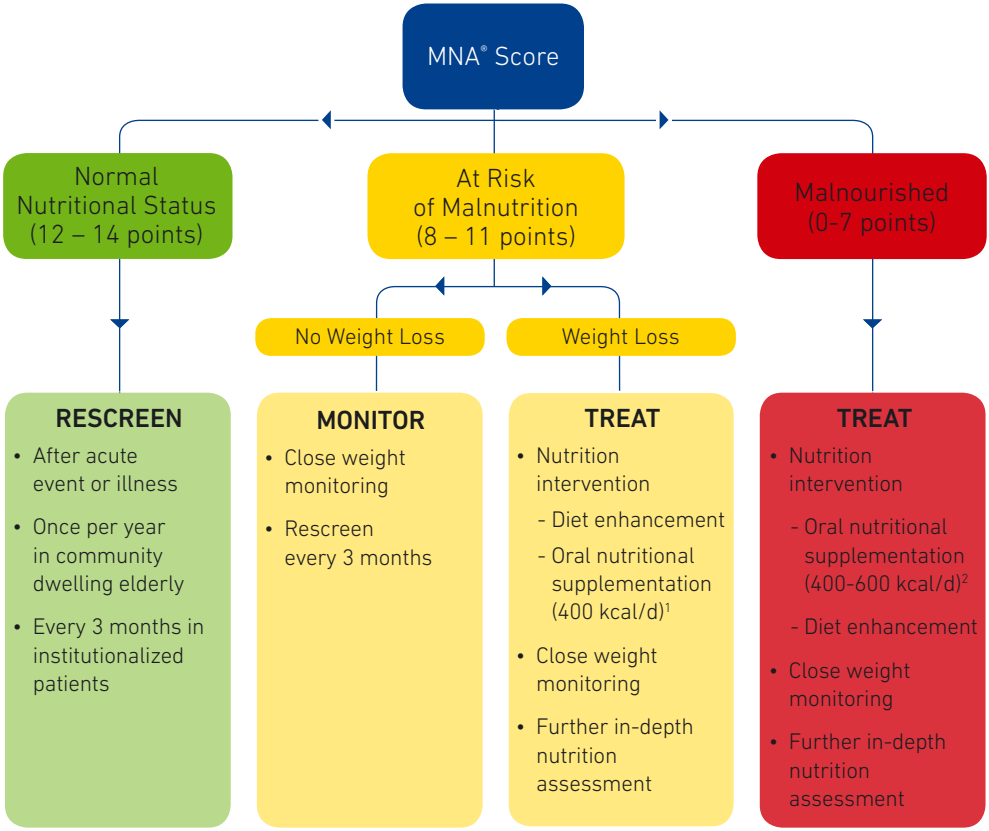
12-14	points:	Normal nutritional status
8-11	points:	At risk of malnutrition
0-7	points:	Malnourished

For proposed intervention, please see the algorithm on the next page.

For more information, go to **www.mna-elderly.com**



Recommendations for Intervention



1. Milne AC, *et al. Cochrane Database Syst Rev.* 2009:**2**:CD003288

2. Gariballa S, *et al. Am J Med.* 2006;**119**:693-699

Note: In the elderly, weights and heights are important because they correlate with morbidity and mortality.

Weight and height measurements are often available in the patient record and should be used as a priority. Only when height and/or weight are unavailable, should Calf Circumference (CC) be used instead of BMI.

Important: When the Calf Circumference is used to complete the MNA®-SF, do not use the full MNA®. Otherwise, the full MNA® score will be inaccurate due to the Calf Circumference measurement being counted twice – once in the MNA®-SF and again in Question R of the full MNA®.

Follow-Up

Rescreen all institutionalized elderly patients every three months and normally nourished elderly patients annually in the community.

Please refer results of assessments and re-assessments to dietitian/doctor and record in medical record.

Appendices

Appendix 1 • Body Mass Index table

MNA® BMI Table for the Elderly (age 65 and above)

Height (feet & inches)

Weight (kg)	4'11"	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	Weight (pounds)
45	20	20	19	18	18	17	17	16	16	15	15	14	14	14	13	13	13	100
48	21	21	20	19	19	18	17	17	16	16	16	15	15	14	14	14	13	105
50	22	22	21	20	20	19	18	18	17	17	16	16	15	15	15	14	14	110
52	23	23	22	21	20	20	19	19	18	18	17	17	16	16	15	15	14	115
55	24	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	120
57	25	24	24	23	22	22	21	20	20	19	19	18	17	17	17	16	16	125
59	26	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	130
61	27	26	26	25	24	23	23	22	21	21	20	19	19	18	18	17	17	135
64	28	27	26	26	24	24	23	23	22	21	21	20	19	19	18	18	18	140
66	29	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	145
68	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	150
70	31	30	29	28	28	27	26	25	24	24	23	22	22	21	20	20	19	155
73	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	20	160
75	33	32	31	30	29	28	28	27	26	25	24	24	23	22	22	21	21	165
77	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	170
80	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	22	175
82	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	180
84	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	185
86	38	37	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	190
89	39	38	37	36	35	34	32	32	31	30	29	28	27	26	26	25	24	195
91	40	39	38	37	35	34	33	32	31	31	30	29	28	27	26	26	25	200
93	41	40	39	38	36	35	34	33	32	31	30	29	29	28	27	26	26	205
95	42	41	40	38	37	36	35	34	33	32	31	30	29	29	28	27	26	210
98	43	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	215
100	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	28	28	220
102	45	44	43	41	40	39	37	36	35	34	33	32	31	31	30	29	28	225
105	47	45	44	42	41	40	38	37	36	35	34	33	32	31	30	30	29	230
107	48	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	234
109	48	47	45	44	43	41	40	39	38	37	35	34	34	33	32	31	30	240
111	49	48	46	45	43	42	41	40	38	37	36	35	34	33	32	32	31	245
114	51	49	48	46	44	43	42	40	39	38	37	36	35	34	33	32	32	250
Height (cm)	150	152.5	155	157.5	160	162.5	165	167.5	170	172.5	175	177.5	180	182.5	185	188	190	

- 0 = BMI less than 19
- 1 = BMI 19 to less than 21
- 2 = BMI 21 to less than 23
- 3 = BMI 23 or greater

This abbreviated BMI table is provided for your convenience and facilitates completing the MNA®. It is accurate for the MNA®. In some cases, calculating the BMI may yield a more precise BMI determination.

2.1 • Measuring height using a stadiometer

1. Ensure the floor surface is even and firm.
2. Have subject remove shoes and stand up straight with heels together, and with heels, buttocks and shoulders pressed against the stadiometer.
3. Arms should hang freely with palms facing thighs.
4. Take the measurement with the subject standing tall, looking straight ahead with the head upright and not tilted backwards.
5. Make sure the subject's heels stay flat on the floor.
6. Lower the measure on the stadiometer until it makes contact with the top of the head.
7. Record standing height to the nearest centimeter.

Accessed at:
http://www.ktl.fi/publications/ehrm/product2/part_iii5.htm
Accessed January 15, 2011.

2.2 • Measuring height using demispan

Demispan (half-arm span) is the distance from the midline at the sternal notch to the web between the middle and ring fingers along outstretched arm. Height is then calculated from a standard formula.[9]

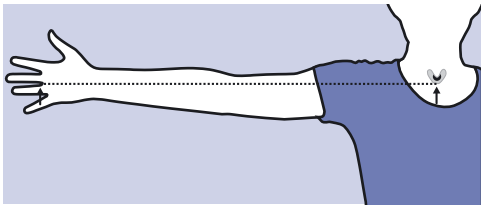
1. Locate and mark the midpoint of the sternal notch with the pen.
2. Ask the patient to place the left arm in a horizontal position.
3. Check that the patient's arm is horizontal and in line with shoulders.
4. Using the tape measure, measure distance from mark on the midline at the sternal notch to the web between the middle and ring fingers.
5. Check that arm is flat and wrist is straight.
6. Take reading in cm.

Calculate height from the formula below:

Females
Height in cm =
(1.35 x demispan in cm) + 60.1

Males
Height in cm =
(1.40 x demispan in cm) + 57.8

Demi-span



Source:
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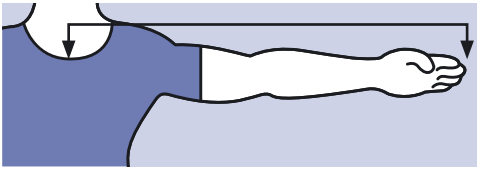
2.3 • Measuring height using half arm-span

Half arm-span is the distance from the midline at the sternal notch to the tip of the middle finger. Height is then calculated by doubling the half arm-span.[10]

1. Locate and mark the edge of the right collar bone (in the sternal notch) with the pen.
2. Ask the patient to place the nondominant arm in a horizontal position.
3. Check that the patient's arm is horizontal and in line with shoulders.
4. Using the tape measure, measure distance from mark on the midline at the sternal notch to the tip of the middle finger.
5. Check that arm is flat and wrist is straight.
6. Take reading in cm.

Calculate height by multiplying the half arm-span measurement by 2

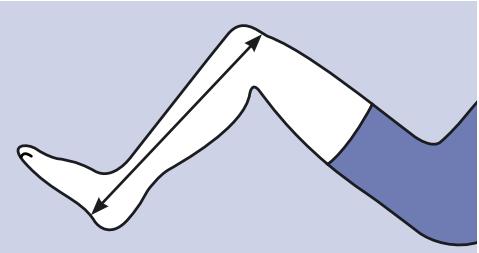
Half arm-span



Source:
http://www.rxkinetics.com/height_estimate.html. Accessed January 15, 2011.

2.4 • Measuring height using knee height

Knee height is one method used to determine statue in the bed- or chair-bound patient and is measured using a sliding knee height caliper. The patient must be able to bend both the knee and the ankle of one leg to 90 degree angles.



Source:
http://www.rxkinetics.com/height_estimate.html. Accessed January 15, 2011.

1. Have the subject bend the knee and ankle of one leg at a 90 degree angle while lying supine or sitting on a table with legs hanging off the table.
2. Place the fixed blade of the knee caliper under the heel of the foot in line with the ankle bone. Place the fixed blade of the caliper on the anterior surface of the thigh about 3.0 cm above the patella.
3. Be sure the shaft of the caliper is in line with and parallel to the long bone in the lower leg (tibia) and is over the ankle bone (lateral malleolus). Apply pressure to compress the tissue. Record the measurement to the nearest 0.1 cm.
4. Take two measurements in immediate succession. They should agree within 0.5 cm. Use the average of these two measurements and the patient's chronological age in the population and gender-specific equations in the table on the right to calculate the subject's stature.
5. The value calculated from the selected equation is an estimate of the person's true stature. The 95 percent confidence for this estimate is plus or minus twice the SEE value for each equation.

Using population-specific formula, calculate height from standard formula:

Population and Gender group	Equation: Stature (cm) =
Non-Hispanic white men (U.S.)[11] [SEE = 3.74 cm]	78.31 + (1.94 x knee height) – (0.14 x age)
Non-Hispanic black men (U.S.)[11] [SEE = 3.80 cm]	79.69 + (1.85 x knee height) – (0.14 x age)
Mexican-American men (U.S.)[11] [SEE = 3.68 cm]	82.77 + (1.83 x knee height) – (0.16 x age)
Non-Hispanic white women (U.S.)[11] [SEE = 3.98 cm]	82.21 + (1.85 x knee height) – (0.21 x age)
Non-Hispanic black women (U.S.)[11] [SEE = 3.82 cm]	89.58 + (1.61 x knee height) – (0.17 x age)
Mexican-American women (U.S.)[11] [SEE = 3.77 cm]	84.25 + (1.82 x knee height) – (0.26 x age)
Taiwanese men[12] [SEE = 3.86 cm]	85.10 + (1.73 x knee height) – (0.11 x age)
Taiwanese women[12] [SEE = 3.79 cm]	91.45 + (1.53 x knee height) – (0.16 x age)
Elderly Italian men[13] [SEE = 4.3 cm]	94.87 + (1.58 x knee height) – (0.23 x age) + 4.8
Elderly Italian women[13] [SEE = 4.3 cm]	94.87 + (1.58 x knee height) – (0.23 x age)
French men[14] [SEE = 3.8 cm]	74.7 + (2.07 x knee height) – (-0.21 x age)
French women[14] [SEE = 3.5 cm]	67.00 + (2.2 x knee height) – (0.25 x age)
Mexican Men[15] [SEE = 3.31 cm]	52.6 + (2.17 x knee height)
Mexican Women[15] [SEE = 2.99 cm]	73.70 + (1.99 x knee height) – (0.23 x age)
Filipino Men[16]	96.50 + (1.38 x knee height) – (0.08 x age)
Filipino Women[16]	89.63 + (1.53 x knee height) – (0.17 x age)
Malaysian men[17] [SEE = 3.51 cm]	(1.924 x knee height) + 69.38
Malaysian women[17] [SEE = 3.40]	(2.225 x knee height) + 50.25

SEE = Standard Error of Estimate[11]

To determine the BMI for amputees, first determine the patient's estimated weight including the weight of the missing body part.[18,19]

- Use a standard reference (see table) to determine the proportion of body weight contributed by an individual body part.
- Subtract the percentage of body weight contributed by the missing body part(s) from 1.0.
- Then, divide the current weight by the difference of 1 minus the percentage of body weight contributed by the missing body part.

Calculate BMI using estimated height and estimated weight.

Example: 80 year old man, amputation of the left lower leg, 1.72 m, 58 kg

1. **Estimated body weight:** Current body weight ÷ (1 - proportion for the missing leg)

   58 (kg) ÷ [1-0.059] = 58 (kg) ÷ 0.941 = 61.6 kg

2. **Calculate BMI:**
   Estimated body weight / body height $(m)^2$

   61.6 ÷ [1.72 x 1.72] = 20.8

Weight of selected body components

It is necessary to account for the missing body component(s) when estimating IBW.

Table: Percent of Body Weight Contributed by Specific Body Parts

Body Part	Percentage
Trunk w/o limbs	50.0
Hand	0.7
Forearm with hand	2.3
Forearm without hand	1.6
Upper arm	2.7
Entire arm	5.0
Foot	1.5
Lower leg with foot	5.9
Lower leg without foot	4.4
Thigh	10.1
Entire leg	16.0

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Osterkamp LK., Current perspective on assessment of human body proportions of relevance to amputees, *J Am Diet Assoc.* 1995;**95**:215-218.

1. The subject should be sitting with the left leg hanging loosely or standing with their weight evenly distributed on both feet.
2. Ask the patient to roll up the trouser leg to uncover to calf.
3. Wrap the tape around the calf at the widest part and note the measurement.
4. Take additional measurements above and below the point to ensure that the first measurement was the largest.
5. An accurate measurement can only be obtained if the tape is at a right angle to the length of the calf, and should be recorded to the nearest 0.1 cm.

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Measuring Calf Circumference in bed-bound persons

1. Have the person being measured lie in supine position with the left knee bent at 90° angle.
2. Slip a loop of the tape measure around the left calf until largest diameter is located.
3. Pull tape so it is just snug but not so tight that tissue is compressed.
4. Read and accurately record measurement to the nearest 0.1 cm. Repeated measurements should agree within 0.5 cm.

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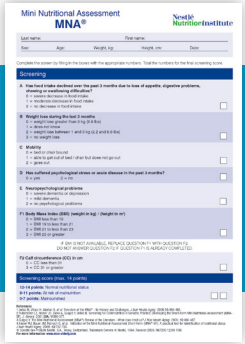

Mini Nutritional Assessment
MNA®

Nestlé Nutrition Institute

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems

F1 Body Mass Index (BMI) (weight in kg) / (height in m²)
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater

F BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater

Screening score (max. 14 points)

12-14 points: Normal nutritional status
8-11 points: At risk of malnutrition
0-7 points: Malnourished

References:
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For more information: www.mna-test.com

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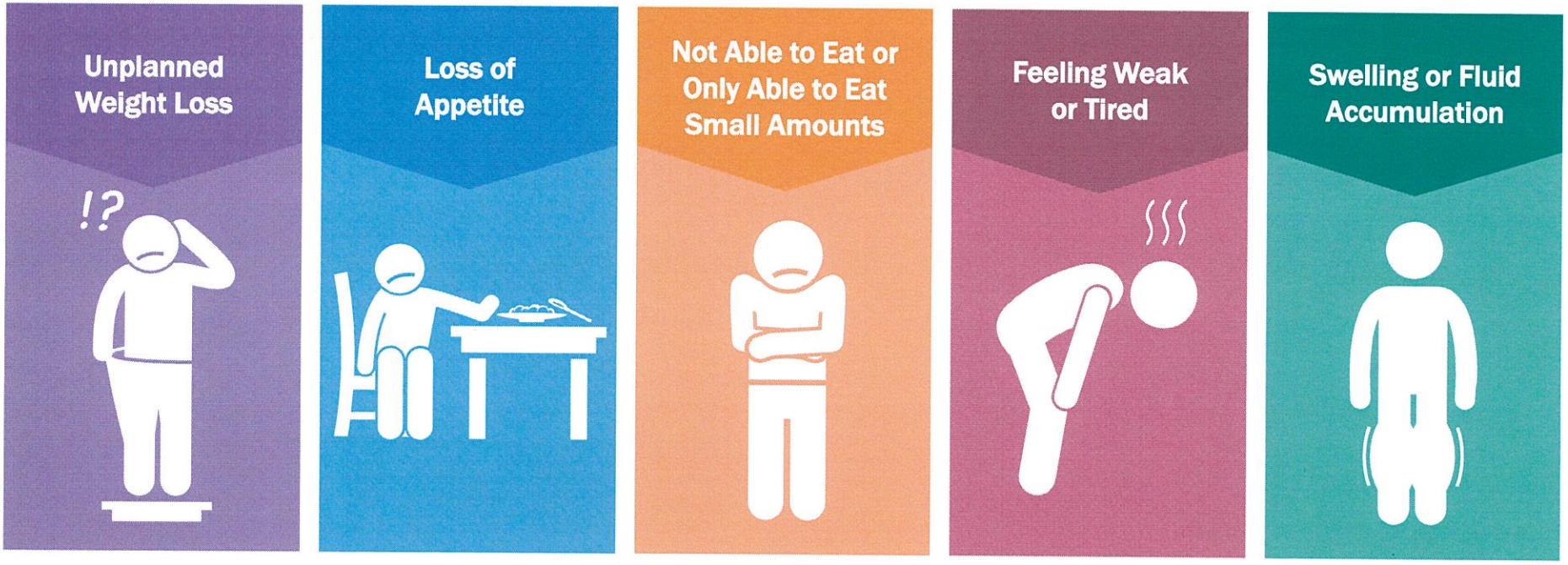

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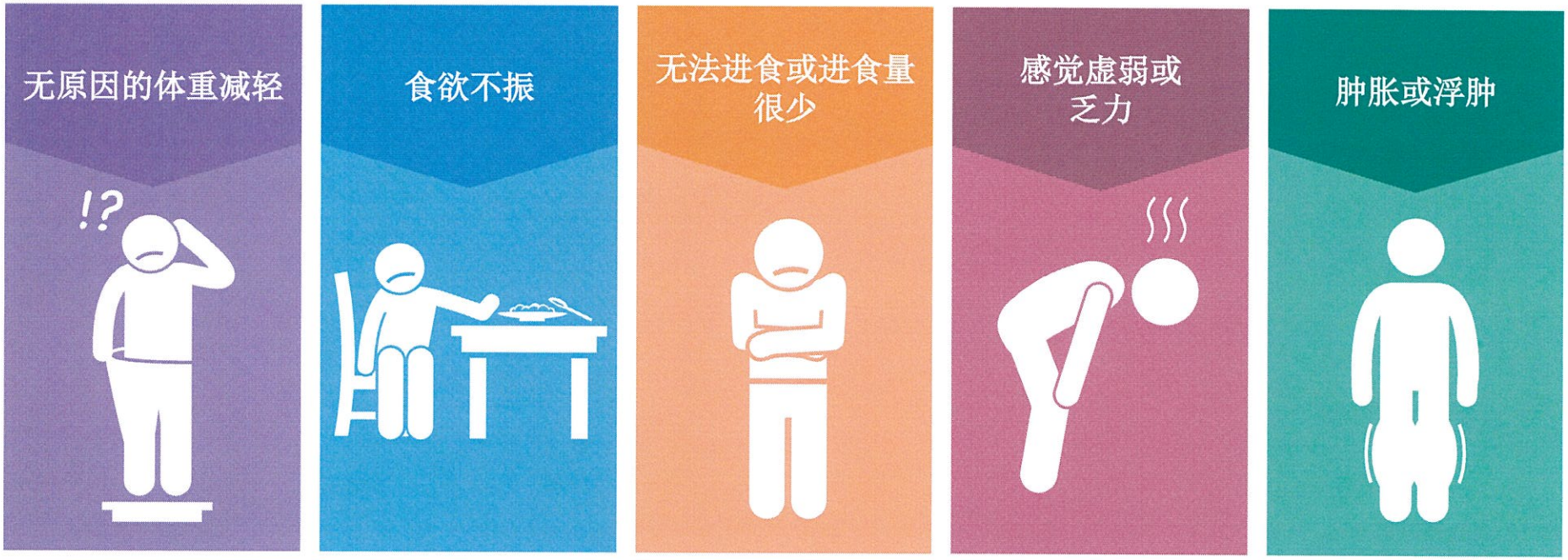
您或您的家人有这些症状吗？



请告知您的健康保健医务人员

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詢問您的營養狀況

好的營養能幫助你預防感染，加速愈合和增強體質

MALNUTRITION AWARENESS WEEK™

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ncoa
National Council on Aging

5 Facts about Malnutrition

FACT 1: Malnourished individuals can come in all sizes

- 715,000 U.S. adults aged 65+ are **underweight**
- 1 in 3 U.S. adults aged 65+ are **overweight**
- You can be underweight or overweight and still malnourished

FACT 2: Malnutrition affects all groups of people

- 9 million older adults **can't afford nutritious food**
- 1 in 4 adults aged 65+ either reduces meal sizes or **skips meals**
- 16% of independent older adults are **at high risk** for malnutrition
- Up to 60% of older adults in **health care settings** are malnourished

FACT 3: Malnutrition can come from a number of factors

- Chronic conditions
- Limited income
- Trouble swallowing/chewing
- Poor dental health
- Changing taste buds
- Living alone
- Medication side effects
- Poor appetite
- Restricted diets
- Lack of mobility
- Depression
- Dementia
- Gastrointestinal disorders

FACT 4: You can't always prevent or treat malnutrition by just eating more

- **Adjust your diet** to get all the nutrients your body needs
- **Exercise** to build muscle and improve strength
- **Consult** a Registered Dietitian Nutritionist
- Consider using an **oral nutritional supplement**

FACT 5: Malnutrition has many warning signs

- Muscle weakness
- Fatigue
- Increased illness or infection
- Feeling irritable or depressed
- Unplanned weight loss
- Decreased appetite

Learn more: ncoa.org/NutritionTools

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