NAME ____

Imbalanced Nutrition/More than Body Requirements

(Obesity/Overweight)

Date	Problem	Goal/Outcome	Interventions	Date	Evaluation	NOTES
	Related To: □ Diagnosis of (state) AEB: ***(check/circle all that apply)*** □ BMI > 30 □ Inability to ambulate independently □ Activity intolerance □ SOB on exertion □other (state)	***(circle all that apply)*** 1. No weight gain noted 2. Lose 1-2 lbs./month 3. Exercise a minimum of 15 minutes, at least 3 times /week 4. Verbalizes appropriate food selection and portions to facilitate weight loss 5. Verbalizes at least 2 complications of being overweight	**NURSING** 1. Initial and ongoing nursing assessment /Review of Systems 2. Assess and monitor weight/BMI ________ (frequency) 3. Teach behavior modification strategies to avoid overeating (specify) 4. Teach complications associated with obesity 5. Assess VS (T/P/R/BP) ________ (frequency) 6. Encourage keeping a food diary at least 3 days a week 7. Encourage adequate water intake (64 oz./day) 8. Encourage exercise/assist with goal setting 9. Consult Dietician as needed 10. Other (state)		***(Address all items listed in "goal/outcome" column. If goal not met, revise plan)***	

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			DELEGATE 1. Assist with meds as ordered/directed 2. Check Vital Signs (T/P/R/BP) ________ (frequency) 3. Weigh _______(frequency) 4. Assist with ADLs as needed/directed 5. Encourage daily exercise according to ability 6. Monitor and encourage appropriate food/liquid intake 7. Monitor and assist with food diary 8. Document I & O a. Encourage a minimum fluid intake of 32 ounces/day b. Notify the MAS Nurse if no BM in 3 days 7. Other (state)			
RN SIGNATURE:					**DATE:**	