

**Nutrition Discharge Planning Instructions**

Patient Name:		DOB:	Discharge Date:
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This patient requires a specialized nutritional plan due to (select all that apply):

<input type="checkbox"/>	Prematurity ( _____ weeks)
<input type="checkbox"/>	IUGR / SGA ( _____ grams)
<input type="checkbox"/>	Suboptimal weight trajectory
<input type="checkbox"/>	Osteopenia of prematurity
<input type="checkbox"/>	Prolonged parenteral nutrition
<input type="checkbox"/>	Volume restriction
<input type="checkbox"/>	Daily use of mineral wasting medications
<input type="checkbox"/>	Other: _____

This infant's discharge feeding plan is as follows:

This infant should continue this feeding recommendation until

- 52 weeks CGA, which will be around the following date: \_\_\_\_\_
- AND / OR
- \_\_\_\_\_ kg / \_\_\_\_\_ percentile

He/she should then transition to: \_\_\_\_\_

Name of NICU Healthcare Provider: \_\_\_\_\_

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

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