**Nutrition Assessment and Management Form**

Region ______________ District ______________ Facility name ______________ Facility code _________

Entry point into NACS (tick one):
- ☐ RCH
- ☐ PMTCT
- ☐ MCH
- ☐ CTC
- ☐ TB/DOTS
- ☐ MVC
- ☐ Other ___________________________

Client number 1 ______________________

Sex (tick one):
- ☐ M
- ☐ F

HIV status (tick one):
- ☐ HIV positive
- ☐ HIV negative
- ☐ Unknown HIV status
- ☐ HIV-exposed child (status unknown)
- ☐ HIV+ pregnant
- ☐ HIV+ up to 6 months post-partum

Age (years) _____ Age group (tick one):
- ☐ 0–6 months
- ☐ 7–11 months
- ☐ 12–23 months
- ☐ 24–59 months
- ☐ 5–14 years
- ☐ 15–17 years
- ☐ 18+ years

Transferred/referred to __________________________ Date ___/___/___

If specialised food products are prescribed: Date of entry ___/___/___ Date of exit ___/___/___ Number of weeks on treatment

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<thead>
<tr>
<th>Visit no.</th>
<th>Date (dd/mm/yy)</th>
<th>Bilateral pitting oedema?</th>
<th>Medical complications?</th>
<th>Appetite? (Y/N)</th>
<th>Length/height (cm)</th>
<th>Weight (kg)</th>
<th>MUAC (cm)</th>
<th>WHZ</th>
<th>BMI or BMI-for-age</th>
<th>Pregnant? (tick if yes)</th>
<th>Counselling on diet? (tick if yes)</th>
<th>Counselling on IYCF (tick if yes)</th>
<th>Nutritional status</th>
<th>Amount of specialised food product given</th>
<th>Follow-up status (tick appropriate)</th>
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1 Use CTC number; if client is referred from another service, use that service’s file number.
2 Client’s condition deteriorated, requiring medical transfer.
3 Client reached target weight, WHZ, BMI or MUAC.
4 Client did not return for three consecutive visits.