

# NUTRITIONAL ADVISOR/NRN RISK-STRATIFICATION SCREENING TOOL (RSST)



*This risk-stratification screening tool does not substitute advice from an appropriately qualified Medical or Allied Health Professional. This risk-stratification screening tool does not promise or warrant against injury or death and no guarantee of protection should result from the use of this risk-stratification tool. No liability or responsibility in any shape or form can be accepted by Nutrition Council Australia (NCA), for any injury, loss, harm or damage that may emerge or become apparent from any person acting on the instruction of (or any statement or information) this risk-stratification screening tool.*

## CLIENT DETAILS:

|                   |        |         |  |
|-------------------|--------|---------|--|
| CLIENT NAME:      |        |         |  |
| DATE:             |        | DOB:    |  |
| CONTACT DETAILS:  | PH:    | GENDER: |  |
|                   | EMAIL: |         |  |
| CLIENT SIGNATURE: |        |         |  |

## SECTION 1: IDENTIFY THE CLIENT'S CURRENT HEALTH STATUS

Due to the increased risk and challenges that medical conditions can have on client care, it is critical that clients who fall outside the scope of practice for a Nutritional Advisor/NRN are identified. Section one of the industry endorsed RSST focuses on identifying the client's current health status and the need for referral.

There are two components within Section 1 of the RSST that collect vital information about the client, these include:

**PART A)** Identify current medical conditions.

**PART B)** Identify 'at risk' factors.

## PART A) IDENTIFY CURRENT MEDICAL CONDITIONS

**OBJECTIVE:** To identify if an individual presents with any known diseases, or signs or symptoms of disease, who may be classified as a higher risk of an adverse event under the guidance of a Nutritional Advisor/NRN.

| The potential client should answer yes or no to the following questions:                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                       | Yes | No |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1                                                                                                                                                                                                                                                                               | Are you pregnant or breastfeeding?                                                                                                                                                                                                                                                                    |     |    |
| 2                                                                                                                                                                                                                                                                               | Are you under the age of 16 years old (0-15 years old)?                                                                                                                                                                                                                                               |     |    |
| <b>The following questions refer specifically to 'chronic health conditions' (an illness persisting for a long time or constantly recurring).</b>                                                                                                                               |                                                                                                                                                                                                                                                                                                       |     |    |
| 3                                                                                                                                                                                                                                                                               | Have you been medically diagnosed with any eating disorder (i.e., anorexia nervosa, anorexia bulimia, binge eating disorder)? <i>If yes, please indicate below:</i>                                                                                                                                   |     |    |
| 4                                                                                                                                                                                                                                                                               | Have you been diagnosed with diabetes mellitus (i.e., pre-diabetes, type I, type II & gestational diabetes)? <i>If yes, please indicate below:</i>                                                                                                                                                    |     |    |
| 5                                                                                                                                                                                                                                                                               | Have you been diagnosed with coeliac disease?                                                                                                                                                                                                                                                         |     |    |
| 6                                                                                                                                                                                                                                                                               | Have you been diagnosed with cancer?                                                                                                                                                                                                                                                                  |     |    |
| 7                                                                                                                                                                                                                                                                               | Have you been diagnosed with renal disease?                                                                                                                                                                                                                                                           |     |    |
| 8                                                                                                                                                                                                                                                                               | Have you ever had bariatric surgery (i.e gastric sleeve, gastric bypass, lap-band)? <i>If yes, please indicate below:</i>                                                                                                                                                                             |     |    |
| 9                                                                                                                                                                                                                                                                               | Have you been diagnosed with any of the following gastrointestinal tract issues? Diverticulitis, bowel obstructions and bowel resections, irritable bowel syndrome (IBS), inflammatory bowel disease (IBD) including ulcerative colitis and/or Crohn's disease. <i>If yes, please indicate below:</i> |     |    |
| 10                                                                                                                                                                                                                                                                              | Have you been diagnosed with thyroid disease (i.e., hypothyroidism or hyperthyroidism)? <i>If yes, please indicate below:</i>                                                                                                                                                                         |     |    |
| 11                                                                                                                                                                                                                                                                              | Are you currently taking any prescribed medication for blood pressure, cardiovascular disease or high cholesterol, such as ACE inhibitors, beta blockers, warfarin or statins? <i>If yes, please list the medication(s) below and provide a reason for taking the medication(s):</i>                  |     |    |
| <b>If the individual answers 'YES' to any of the above 11 questions, a referral must be made to an Accredited Practising Dietitian (APD) for nutritional advice and support.</b><br><i>*A Nutritional Advisor/NRN must not work with or take the individual on as a client.</i> |                                                                                                                                                                                                                                                                                                       |     |    |
| <b>If the individual answers 'NO' to all of the 11 questions above, the Nutritional Advisor/NRN can move onto Section 1: B of the Risk-Stratification Screening Tool.</b>                                                                                                       |                                                                                                                                                                                                                                                                                                       |     |    |

## PART B) IDENTIFY 'AT RISK' FACTORS

**OBJECTIVE:** To identify if an individual presents with any risk factors in which a Nutritional Advisor/NRN would need to refer the individual to a GP for a more detailed assessment and gain medical clearance prior to working with the individual.

| The potential client should answer yes or no to the following questions:                                                                                                                                                                                                                                                                         |                                                                                                                                                                                               | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1                                                                                                                                                                                                                                                                                                                                                | Is your BMI below 18.5kg/m <sup>2</sup> (<18.5) or above 40kg/m <sup>2</sup> (>40)?<br>BMI = kg/m <sup>2</sup> = Weight ÷ (height x height)<br><i>If yes, please indicate your BMI below:</i> |     |    |
| 2                                                                                                                                                                                                                                                                                                                                                | Have you been diagnosed with any conditions impacting fertility (i.e., polycystic ovarian syndrome, endometriosis)? <i>If yes, please indicate below:</i>                                     |     |    |
| 3                                                                                                                                                                                                                                                                                                                                                | Have you been formally diagnosed with any food allergies and/or intolerances?<br><i>If yes, please specify food allergy, diagnostic tool and an approximate diagnosis date:</i>               |     |    |
| 4                                                                                                                                                                                                                                                                                                                                                | Have you been formally diagnosed with a mental health condition in which you are required to take medication?                                                                                 |     |    |
| <p><b>If the individual answers 'YES' to any of the above 4 questions, a referral must be made to a General Practitioner (GP) for a more detailed assessment and a medical clearance.</b><br/> <i>*It is only after a clearance and the 'all clear' has been made by the GP that a Nutritional Advisor/NRN can work with the individual.</i></p> |                                                                                                                                                                                               |     |    |
| <p><b>If the individual answers 'NO' to all 4 questions above, the Nutritional Advisor/NRN can move onto Section 2 of the Risk-Stratification Screening Tool.</b></p>                                                                                                                                                                            |                                                                                                                                                                                               |     |    |

## SECTION 2: IDENTIFY POSSIBLE FOOD INTOLERANCES/ALLERGIES

**OBJECTIVE:** This section identifies possible food intolerances or allergies that an individual may have. This is an important factor in the screening process to identify if an individual may suffer from food intolerances and/or allergies as this may require a more detailed level of assessment by a General Practitioner (GP).

| The potential client should answer yes or no to the following questions: |                                                                                                                                                                                                                                                                                        | Yes | No |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1                                                                        | Do you experience bloating regularly?                                                                                                                                                                                                                                                  |     |    |
| 2                                                                        | Do you believe you suffer from excessive flatulence?                                                                                                                                                                                                                                   |     |    |
| 3                                                                        | Do you experience irregular bowel motions (i.e., diarrhoea, constipation, sore to pass, abnormal colours, faecal urgency)?<br><i>If yes, please provide details below on the number of eliminations per day, stool colour, stool abnormalities and stool formation where possible:</i> |     |    |
| 4                                                                        | Do you believe you suffer from low energy levels?<br><i>If yes, please provide more information below:</i>                                                                                                                                                                             |     |    |
| 5                                                                        | Do you suspect you may have any food allergies and/or intolerances?<br><i>If yes, please identify why you think you may have an allergy/intolerance and to what specific food:</i>                                                                                                     |     |    |

**If the individual answers 'YES' to two (2) or more of the above 5 questions, it is 'recommended', however, not mandatory that a referral be made to a General Practitioner (GP) for a more detailed assessment and a medical clearance.**

*\*It is to the discretion of both the individual and the Nutritional Advisor/NRN whether or not nutritional support and guidance will continue under the supervision of the Nutritional Advisor or if the client will be referred to a GP. If the client is happy to receive support under the guidance of the Nutritional Advisor/NRN, then the Nutritional Advisor/NRN can continue to work with the client.*

**If the individual answers 'NO' to all of the above 5 questions, the Nutritional Advisor/NRN can begin to provide individual nutritional support and guidance to the client.**

## SECTION 3: IDENTIFY FAMILY HEALTH HISTORY

**OBJECTIVE:** This section identifies possible chronic health conditions that present within immediate family members. Having a family health history of a chronic condition does not mean that the client will develop that condition, however, it is important to identify any potential risks.

| The potential client should answer yes or no to the following questions: |                                                                                                                                                                                                            | Yes | No |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <b>1</b>                                                                 | Has an immediate family member (parents or siblings) ever been diagnosed with any of the chronic health conditions outlined in Section 1: A?<br><i>If yes, please list the medical condition(s) below:</i> |     |    |
| <b>2</b>                                                                 | If you have answered 'yes' to the above question, have you had a health check within the last 12 months and been cleared for that condition?                                                               |     |    |

It is recommended that the client undergoes a health check with their practitioner (GP) if they have answered 'YES' for question 1 and 'NO' for question 2 (i.e., they have indicated there is a family history of chronic disease and have not had a health check within the last 12 months).

The Nutritional Advisor/NRN can begin to provide individual nutritional support and guidance to the client even if a family history of chronic conditions has been indicated, however, clients should be encouraged to have regular health checks.

**ADDITIONAL NOTES (IF REQUIRED):**