# STATE OF NEW JERSEY
# DEVELOPMENTAL DISABILITIES
# NUTRITION ASSESSMENT FORM (NAF)

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Prepared for State of New Jersey
Division of Developmental Disabilities

Consumer Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

**PURPOSE**

***THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE CONSUMER.***

***YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.***

***PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE CONSUMER'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.***

***THANK YOU FOR YOUR ASSISTANCE.***

1. Please indicate whether any special services have been performed for the consumer in the **last 3 months.**

| | | NO | YES |
|---|---|---|---|
| a. | Any increases in fluids? | 0 | 1 |
| b. | Tube feeding? | 0 | 1 |
| | (Answer c-d for all consumers who receive food by mouth. If tube fed only – skip c-d.) | | |
| c. | Special food preparation (e.g., pureed, chopped)? | 0 | 1 |
| d. | Special dietary foods or restrictions (e.g., low salt)? | 0 | 1 |

2. Regardless of where the consumer lives, what services, if any, might be necessary from a dietitian for a specialized diet?

    1. None Needed
    2. Needed on an Occasional Basis
    3. Needed on a Frequent Basis

**Thank you for your assistance!**