CLINICAL PATHWAY:
Eating Disorder

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Inclusion Criteria: Established or newly diagnosed eating disorder AND moderate or severe malnutrition[1]
Exclusion Criteria: Active gastrointestinal pathology causing malnutrition

PCP and/or ED Assessment

History of: weight loss, binging/purging, diet (intake), alcohol or substance use, medications, exercise, syncope, menstrual periods

Physical: height & weight with % median body mass index (% mBMI - see Appendix A), orthostatic BP and HR (BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min), hydration status, cardiac and peripheral exam, signs of intentional vomiting (dental erosion, knuckle abrasions)

Pre-treatment evaluation

Chem 10, AST/ALT, GGT, alkaline phosphatase, ferritin, % iron saturation, T4 & TSH, albumin, pre-albumin, triglycerides, CBC w/differential, ESR, IgA, TTG IgA, UA, urine for hCG, 12-lead EKG
(if tests were recently completed, use provider discretion whether or not to repeat)

Admission Criteria[2]

No

- Patient does not meet inpatient criteria
- Consider behavioral health consult for partial hospitalization programs or outpatient counseling, and notify PCP
- May always call Psychiatry or Hospital Medicine to discuss

Yes

Admit to Hospital Medicine

- PCP or ED provider reviews clinical pathway management with patient and family[3]
- ED provider gives patient and family the Patient Handout that outlines expectations during the admission (see Appendix C)
- If patient ≥ 18 years, must call hospitalist to discuss admission

Inpatient Initial Management

- Patient handout to be given to and signed by the patient and family at time of admission (see Appendix C)
- Place patient in 1:1 observation per Appendix B
- Place patient on continuous CR monitoring
- Order strict I/O's
- Place appropriate consults. Calls for consults may need to be placed the following morning if late admission.
  - Psychiatry consult for all patients
  - Nutrition consult for all patients
  - Consult GI if presence of dysphagia or recurrent choking, or concerns for GI pathology, or if patient referred by GI or is an established GI patient
- PCA to print Nursing/PCA Job Aid (Appendix B) and Nursing/PCA Protocol Worksheet (Appendix I)

If Anorexia/Bulimia:

- Proceed to page 2: Anorexia/Bulimia Inpatient Management

If Avoidant Restrictive Food Intake Disorder (ARFID)[4]:

- Proceed to page 3: ARFID Inpatient Management

[2]Admission Criteria:

*Must be established or newly diagnosed eating disorder **AND** moderate or severe malnutrition **AND** one or more of the following:*

- <75% mBMI OR <80% mBMI if < 10 year of age or pre-menarchal
- Acute food refusal > 24hrs
- HR ≤40 bpm supine & resting (consider if ≤45 with other criteria)
- Systolic BP <80 mmHg
- Orthostatic changes in SBP (>20 mmHg)
- Syncope or pre-syncope with standing
- Electrolyte disturbances (e.g. hypokalemia, hypophosphatemia, hypomagnesemia, hypochloremia)
- Dehydration
- Temperature <36°C
- Arrhythmia (prolonged QTc)
- Intractable vomiting or hematemesis
- Failure of outpatient treatment

[1]Malnutrition Defined:

	Moderate	Severe
% mBMI	70-79%	<70%
BMI z score	-2 to -2.9	-3 or greater
Weight Loss	≥7.5% in 6 months	≥10% in 6 months

[3] Example script for ED when notifying of admission:

"Your child is being admitted for medical stabilization for malnutrition due to disordered eating. The treatment requires a structured approach, with slow and gradual re-introduction of nutrition in a safe way. There is an initial restriction of activity, which is advanced based on medical stability."

[4]Avoidant Restrictive Food Intake Disorder (ARFID) Definition:

Disordered eating due to one of the following:

- Concern about unpleasant consequences of eating, such as pain, vomiting, choking
- Avoidance based on sensory qualities
- Seeming lack of interest in eating or food

NEXT PAGE

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

CLINICAL PATHWAY:
Eating Disorder
Anorexia/Bulimia Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

VITAL SIGNS Q4HR

Orthostatics:

- Instructions for obtaining orthostatics: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- Obtain 1st set on admission
- If orthostatic for BP or HR, take daily until normalized (positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20)

Weight:

- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Neither patient nor family are to be told the weight
- Obtain growth charts from PCP

LABS & DIAGNOSTICS

Day 1:

- Consider echocardiogram for any patient with a positive cardiac ROS or at provider discretion based upon severity of malnutrition (in echo order, select "Eating Disorder patients")

If not previously obtained in the ED:

- UA
- Urine hCG (female pts)

Days 2-5:

- i-STAT Chem 10 daily for 5 days, then PRN based on risk of refeeding syndrome

** If patient is admitted in the evening/night and admission chem 10 is normal, do not need to repeat chem 10 on the 1st morning*

NUTRITION & FLUIDS

Nutrition:

See **Appendix D** for Anorexia and Bulimia diet plans

- Initiate meal plan immediately after admission lab results reviewed
- RD will ask patient for 3 food dislikes
- Advance diet based on PO compliance (includes water intake) and medical necessity until weight gain is achieved with advancement of activity
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of free water and then adjust per RD recommendations
- See **Appendix F** for Ensure replacement guideline
- Place nasogastric tube (NGT) after snacks if not 100% compliant with caloric goals (**Appendix D** regarding NGT feedings)

IV Fluids:

- Consider NS bolus and/or continuous IVFs if severe dehydration or patient refusing PO fluids (consider smaller bolus if signs of heart failure)

MEDICATIONS

Anorexia:

- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Consider Tums for low calcium levels
- Consider oral phosphorus if serum phos < 3 mg/dL [Phos-NaK contains 250mg Phos, 160mg (7mEq) Na, 280mg (7.2mEq) K]
- Consider IV phos supplement if phosphate level ≤ 2mg/dL

Bulimia:

- Consider IV phos supplement if phosphate level ≤ 2mg/dL
- Consider sodium bicarbonate or oral Bicitra if bicarbonate levels are low
- Consider potassium supplement if low serum K and normal pH (indicates dangerous reduction of total body K)

ACTIVITY & 1:1 OBSERVATION STATUS

Activity

Advancement based on increasing medical stability.

Level 1 (start at admission):

- Strict bed rest due to VS instability
- OOB for bathroom use only

Level 2: (usually by 24 hours)

- Advance to this level once BP and orthostatic symptoms stabilize (may still be orthostatic by HR)
- OOB in room for meals
- OOB in wheel chair for limited scheduled activities as determined by medical team
- Shower based on medical & psych clearance

Level 3:

- Advance to this level once oral intake promotes weight gain or weight stability
- First, ad lib activity in the room
- Then, advance to 1-3 five-minute walks per day (may advance more slowly or rapidly based upon medical stability)

Observation:

- Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despite adequate nutrition (**Appendix B**)

Reinforcement and Meal Support

Reinforcement:

- All safe patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all admitted patients
- No personal mobile devices
- If an additional reinforcement plan is needed to support compliance with nutrition, then additional reinforcers will be used from Child Life services, including but not limited to:
  - iPad
  - Kindle
  - Nintendo Switch
  - Xbox One

Meal Support

- See **Appendix B**: Nursing/PCA Job Aid and **Appendix G**: Meal Support Strategies
- See **Appendix I** for nursing/PCA protocol worksheet

Discharge Criteria/Medications:

- Medically cleared with stable labs and vital signs
- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
- Appropriate placement arranged in inpatient, PHP or outpatient program with psychiatry team input
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Connecticut Children's

CLINICAL PATHWAY:
Eating Disorder
ARFID Inpatient Management

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

VITAL SIGNS Q4HR

Orthostatics:

- Instructions for obtaining orthostatics: BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- 1st set on admission
- If orthostatic for BP or HR, take daily until normalized (positive if SBP drops by ≥ 20 mmHg or DBP by ≥ 10 mmHg, HR increase by ≥ 20)

Monitoring:

- Place on cardiorespiratory monitor
- Discontinue continuous monitor at Level 3 activity

Weight:

- Weigh patient QAM after 1st void and before breakfast
- Weight to be done in hospital gown only (no socks, underwear etc.)
- Neither patient nor family are to be told the weight
- Obtain growth charts from PCP

LABS & DIAGNOSTICS

Day 1:

- Consider echocardiogram for any patient with a positive cardiac ROS or at provider discretion based upon severity of malnutrition (in echo order, select "Eating Disorder patients")

If not previously obtained in the ED:

- UA
- Urine hCG (female pts)

Days 2-5:

- i-STAT Chem 10 daily for 5 days, then PRN based on risk of refeeding syndrome

** If patient is admitted in the evening/night and admission chem 10 is normal, do not need to repeat chem 10 on the 1st morning*

NUTRITION & FLUIDS

Nutrition:

Appendix E for ARFID plans

- Initiate meal plan immediately after admission lab results reviewed
- RD will identify food likes, which will make up a large portion of meals
- Advance diet based on PO compliance (includes water intake) and medical necessity until weight gain is achieved with advancement of activity
- Place next day's diet order after evening snack by modifying existing diet order
- Start with 24oz of free water and then adjust per RD recommendations
- See Appendix F for Ensure replacement guideline
- The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team (Appendix E regarding NGT feedings)

IV Fluids:

- Consider NS bolus and/or continuous IVFs if severe dehydration or patient refusing PO fluids (consider smaller bolus if signs of heart failure)

MEDICATIONS

- Complete multivitamin 1 tablet daily
- Thiamine 100 mg/day x7 days total
- Consider Tums for low calcium levels
- Consider oral phosphorus if serum phos < 3 mg/dL [Phos-NaK contains 250mg Phos, 160mg (7mEq) Na, 280mg (7.2mEq) K]
- Consider IV phos supplement if phosphate level ≤ 2mg/dL

ACTIVITY & 1:1 OBSERVATION STATUS

Activity

Advancement based on increasing medical stability.

Start at Level 2:

- If hypotension or symptomatic othostasis, start at Level 1: bedrest until stabilizes (may still be orthostatic by HR)
- OOB in room for meals
- OOB in wheel chair for limited scheduled activities as determined by medical team
- Shower based on medical & psych clearance

Level 3:

- Advance to this level once oral intake promotes weight gain or weight stability
- First, ad lib activity in the room
- Then, advance to 1-3 five-minute walks per day (may advance more slowly or rapidly based upon medical stability)

Observation:

- Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despite adequate nutrition (Appendix B)

Reinforcement and Meal Support

Reinforcement:

See Appendix H ARFID Behavioral Plan

- Behavioral plan will be created with multidisciplinary input, identifying:
  - Patient motivators
  - Reinforcers for small goals
  - Reinforcers for large goals
  - Less desirable activities when goals are not met

Meal Support

- See Appendix B: Nursing/PCA Job Aid and Appendix G: Meal Support Strategies
- See Appendix I for nursing/PCA protocol worksheet

Discharge Criteria/Medications:

- Medically cleared with stable labs and vital signs
- Patient adherent to prescribed nutrition plan with weight gain, especially with ad lib activity
- Appropriate placement arranged in inpatient, PHP or outpatient program with psychiatry team input
- Medications at discharge: complete multivitamin; thiamine (if 7 days not complete)

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Connecticut Children's

Steps:

1. Find patient's BMI using the following link (need patient's height & weight):
   Calculate Your BMI - Metric BMI Calculator (nih.gov)
2. Using a CDC growth/BMI chart (or one of the links below):
   BOYS:
   2 to 20 years: Boys, Body mass index-for-age percentiles (cdc.gov)
   GIRLS:
   2 to 20 years: Girls, Body mass index-for-age percentiles (cdc.gov)

   Find the BMI at the 50th percentile* for the patient's age.

3. % Median BMI (mBMI) = Patient's BMI ÷ BMI at 50th %* for age

   Example:
   15 year old girl has a BMI of 14 (based on entering her height & weight in Step #1)
   BMI at 50th percentile for age = 20 (based on BMI chart in Step #2)

   % mBMI = 14 ÷ 20 = 70%

** The dietitian and/or medical team may adjust the patient's % mBMI to a different BMI %ile (other than 50th%ile) based on the patient's previous growth history (e.g. if the patient has tracked at the 25th percentile prior to weight loss, use this for mBMI calculation).*

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Vital Signs: q4hr

Orthostatic vital signs ("Orthostatics") HR and BP when supine and standing:

- Obtain 1st set on admission
- BP + HR after patient supine for 3 min, then repeat after patient standing for 3 min
- If Orthostatic for BP or HR, take daily until normalized

Weight:

- Weigh patient qAM after 1st void and before breakfast
- Weigh patient in hospital gown only (no socks, underwear etc.)
- Neither patient nor family are to be told the weight (may be told up, down or the same)

Lowest heart rate per shift

- PCA document the lowest heart rate noted each shift in the vital signs flowsheet in Epic

Nutrition and Fluids:

- See **Appendix C** (Patient Handout) for detailed Meal Guidelines. See **Appendix D** for Anorexia and Bulimia meal plan, & **Appendix E** for Avoidant Restrictive Food Intake Disorder (ARFID) meal plan
- Staff must check tray for accuracy before each meal
- Staff remove meal ticket from tray, document meal completion on meal ticket, and save in the patient's thin chart for 48 hours
- Makeup liquid nutrition supplement will be offered with snacks 3 times per day as needed if not 100% compliant with meals
- NG tube will be placed after each snack if not 100% compliant with makeup
- NG tube exceptions: Consider waiting in patients <11 years. Consider not removing/replacing if NG tube is needed twice or more regardless of age.

1:1 Observation status:

- Patients without purging behaviors will be admitted with 1:1 observation during meals and for 1 hour after nutrition is completed if no exclusion criteria are present
- Patients with purging behaviors will be admitted with 1:1 observation during meals and for 2 hours after nutrition is completed if no exclusion criteria are present
- Patients will have continuous 1:1 observation during any time an NG or NJ tube is present.
- Patients will be placed on continuous 1:1 observation for 24 hours a day, if they meet any of the following exclusion criteria at any point during hospitalization. Exclusion criteria include:
  - active suicidal ideation or self-harm behaviors
  - concern for excessive exercise in treatment setting or home
  - concern for water loading in treatment setting or home
  - high fall risk
- Based on daily review of progress, or at any time exclusion criteria are identified, care team can escalate to a higher observation level. For example, if the patient is not gaining weight despite adequate nutrition
- For select cases, team can consider environmental controls in the room
- Team will review daily whether family members are suitable to begin training for meal support and/or support following meals that could replace the sitter

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

1:1 observation specifics:

- Recommend patient use bathroom before meals
- Make bed in preparation for meal. If patient is on activity level 1 and eating meals in bed, patient must lay/sit on blankets
- For activity level 2 and higher, patient must eat sitting in a chair without blankets
- Sitter remains in the room at the bedside during meals and for the observed time after completion of the nutrition. The 1:1 observing for an extended time beyond meals may then move to the doorway, unless an order is placed stating otherwise.
- The computer should remain outside of the room when the sitter is at the bedside
- Monitor for and document on **Appendix I** (Observation Worksheet) attempts at hiding or vomiting food
- Monitor for and document on **Appendix I** (Observation Worksheet) eating behaviors such as cutting food into tiny pieces, moving food around on the plate, excessive chewing, gagging, etc.
- Provide meal support by utilizing strategies such as supportive comments and distractions (refer to **Appendix G:** Meal Support Strategies)
- We ask that families and staff do not discuss meals, weight, or other eating-related topics, as these topics may raise anxiety.

Eating disorder secure room:

- Before admission:
  - Remove trash receptacles, bins, tissue boxes that could be used to hide food or purge into
  - Remove excessive linens/blankets
  - Consider covering mirror in room
- Bedside curtains must be kept open, except when dressing
- Lights remain on during the day except brief naps
- Bathroom use is supervised by staff with door cracked open when on 1:1 observation
- Staff will measure all urinary output and stool

Any earned privileges materials will be stored at night after bedtime

Activity Status:

Patient will be admitted to Activity Level 1. Activity level is advanced based on increasing medical stability. Providers use the eating disorder order set to change activity level.

Level 1:

- Strict bed rest due to vital sign instability
- Out of Bed for bathroom use only

Level 2: Advance to this level once BP and orthostatic symptoms stabilize (may still be orthostatic by HR)

- Out of bed in room for meals
- Out of bed in wheelchair for scheduled floor activities as determined by medical team
- Shower based on medical and psychiatric team clearance

Level 3: Advance to this level once oral intake promotes weight gain

- First, ad lib activity in room
- Then, advance to 1 to 3 five minute walks per day (advancement based on medical stability)

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Reinforcement:

See **Appendix H** for ARFID behavior plan

- All safe patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all patients
- No personal mobile devices
- For patients with anorexia and bulimia: If an additional reinforcement plan is needed to support compliance with nutrition, then additional reinforcers will be used from the child life service including, but not limited to iPad, Kindle, Nintendo Switch, Xbox One.
- For patients with ARFID: A behavioral plan will be created with multidisciplinary input identifying behavioral expectations and reinforcement for meeting nutritional expectations.
- Do not start homework. Will be considered per psych team.

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

You have been admitted to the hospital because your physician determined that it was medically necessary to hospitalize you to ensure your safety and restore your physical health. This protocol was developed to assure that your hospitalization achieves these goals. If you have any questions about this protocol, please discuss with your nurse or doctor. Your team will keep you up to date with your progress during your hospital stay.

Patient Protocol

Wake Up/Dress Guidelines:

1. At the time of admission, you will be asked to dress in a hospital gown.
2. You need to wake up, get weighed and be dressed prior to breakfast.
3. Clothing per medical team determination.

Weight Guidelines:

1. You will need to be weighed daily before breakfast, after the first morning urination, in a hospital gown only. No other clothing (i.e. underwear, socks, slippers, or shoes) will be worn.
2. You will use the bathroom to urinate prior to being weighed.
3. No jewelry is to be worn.
4. You may not eat, drink, bathe, or brush your teeth before getting weighed.
5. You must stand on the scale with your back toward the weight.
6. Neither you nor your family will be told your actual weight, but you can be told the general trend of up, down, or the same.

Meal Guidelines:

1. There will be 6 mini-meals per day. Each day, if you are 100% compliant, your meals will be advanced through a system, as directed by your Registered Dietician (RD), who will be in charge of creating balanced meal plans that meet your nutritional and caloric needs. All meals will be supervised by staff.
    a. Food meal plans will be provided starting on the first full day on the protocol. If you are admitted in the evening hours or overnight, you will be provided crackers and liquid nutrition supplement such as Ensure for that meal time until the following morning. If you are admitted in the morning or mid-day, it will be determined by the medical team if you can start with food meals immediately.
2. There will be no visitors and no activities allowed during mealtime, except for meal support from a family member or the Patient Care Assistant (PCA). The readiness of a family member to provide meal support will be determined by the psychiatry team after initial evaluation, observation and education with the family.
3. Staff will check your tray for accuracy prior to each meal. No food substitutions are allowed.
4. You will have 30 minutes to complete each mini-meal. After that time, the tray will be removed from your room.
5. Approximate meal times are:
    Breakfast = 8:00am – 8:30am
    Snack = 10:00am – 10:30am
    Lunch = 12:00pm – 12:30pm
    Snack = 2:30pm – 3:00pm
    Dinner = 5:00pm – 5:30pm
    Snack = 8:30pm – 9:00pm

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

6. Staff will record food intake on a meal ticket.
7. No food, beverages, cups, or dishes are allowed in your room, including the food/beverage of family members.
8. Meal plans are advanced based on compliance and will begin at breakfast the next morning.
9. 100% compliance with daily nutrition (food & water) is expected.
10. If you are unable to meet 100% compliance, you will have the opportunity to take in the missed nutrition from a meal at the next snack by drinking a nutrition supplement.
11. If you are unable to make up the nutrition from the liquid nutrition supplement, a feeding tube, called a Nasogastric Tube (NGT) will be considered. An NGT will be placed at the end of each snack time if you do not consume the goal nutrition for that snack and the prior meal. The remainder of the nutrition will be provided with a nutrition supplement via the NGT. The NGT will be taken out when it is completed. You will then have a "fresh start" to be able to achieve 100% compliance with the next meal and snack.
12. You will make your bed in preparation for each meal. If you are on activity level 1 you will eat meals in bed and must lay/sit on blankets. For activity level 2 and higher, you must eat sitting in a chair without blankets.

Unit Environment:

1. The family kitchen is off limits.
2. Lights must remain on during the day.
3. Bedside curtains must be kept open, except when dressing.
4. There is no bathroom use for 1 hour after the end of meals or for 2 hours after the end of meals if there is a history of purging.
5. Bathroom use is supervised by staff with door cracked open when on 1:1 observation.
6. Staff will measure urinary and stool output after each bathroom use.
7. You will be placed on 1:1 observation on admission. *This means there will be a staff member with you to provide safety and support, and to monitor for any disordered eating behaviors.*
    a. Patients without purging behaviors will be admitted with 1:1 observation during meals and for 1 hour after nutrition is completed if no exclusion criteria are present
    b. Patients with purging behaviors will be admitted with 1:1 observation during meals and for 2 hours after nutrition is completed if no exclusion criteria are present
    c. Patients will have continuous 1:1 observation during any time an NG or NJ tube is present.
    d. Patients will be placed on continuous 1:1 observation for 24 hours a day, if they meet any of the following exclusion criteria at any point during hospitalization. Exclusion criteria include:
        i. active suicidal ideation or self-harm behaviors
        ii. concern for excessive exercise in treatment setting or home
        iii. concern for waterloading in treatment setting or home
        iv. high fall risk
8. Inappropriate language or threatening behavior is not acceptable.
9. All medications brought from home must be given to your nurse upon admission.
10. We ask that families do not discuss meals, weight, or other eating-related topics, as these topics may raise anxiety. The treatment team will help guide the family as to appropriate discussions and meal support.

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Visiting:

1. Immediate family and clergy may visit at any time, except mealtime, unless otherwise ordered by the team.
2. Visits with friends and extended family members will be considered once medical stability is achieved and in accordance with current hospital visitation guidelines.

Activity:

1. All patients are admitted on bedrest.
2. You will be placed on a cardiac monitor upon admission. *This means stickers on your chest will measure your heart rate and breathing.* The duration of cardiac monitoring depends on your medical condition.
3. Vital signs (blood pressure, heart rate, breathing rate and temperature) will be taken at least every 4 hours, or more frequently, if your medical condition warrants.
4. Any transports for medical care off the unit must be via wheelchair or stretcher.
5. Activity level will be advanced as the medical status improves.
    a. All patients are admitted on Activity 1 (bed rest) and activity is progressed as nutritional status stabilizes and will be identified by level 1, 2, and 3 with increasing ability to leave the room in a wheelchair and move about the room out of bed.
    b. Medical stability requirements for each activity level can be described by the medical team in the sequence per protocol.
    c. The patient and family will be updated daily regarding advancements in activity level.
    d. If the family and/or patient need clarification of a privilege or activity level, they are encouraged to check with the medical team, nurse, or PCA.

Reinforcement:

1. All safe patients will be admitted to a standard room with access to usual comfort items and child life activities that are available to all patients
2. No personal mobile devices
3. A behavioral plan will be considered if it is needed to support nutritional stabilization
4. All activities will be stored and/or turned off (e.g. television, video games, crafts) before meals and at bedtime.

Date Reviewed with Patient: _____

Patient Signature: _____
(signature indicates patient received a copy of this handout)

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

The goal of the meal plan for the first 4 days is to prevent further weight loss and to encourage the patient to eat by mouth. The patient may not gain weight initially.

Do not share calorie levels with patient.

- The meal plan consists of 3 meals and 3 snacks
- The Registered Dietician (RD) will choose the meal plan to meet the patient's nutritional needs
- Minimum of 24oz of water per 24-hour period
- No additional coffee, tea, diet soda, or juice
- If initial diet order is placed after 1800, each meal that first night will be 230 ml of Ensure + 1 packet of saltine crackers or food chosen by the parent or guardian. These can be initiated and provided in the ED or upon arrival to the floor. PCA will document everything consumed the EPIC flowsheet.
- The patient will be allowed to choose 3 food dislikes, and will be told that the dislikes will be started on the following day

- **Step One:** (1500 total calories per day)
  Begins the first meal after admission through a minimum of 1 calendar day
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- **Step Two:** (1800 total calories per day)
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- **Step Three:** (2100 total calories per day)
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- **Step Four:** (2400 total calories per day)
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- Increase intake by 20% or 200-300 kcal/day to initial goal set by Clinical Nutrition.
  Step numbers continue to advance until reach adequate intake, as determined by weight stability or weight gain with advancing activity based on patient need

If a patient does not finish an entire meal (breakfast, lunch, dinner), he/she will have the opportunity to take in the missed calories at the next snack by drinking a liquid nutrition supplement (Refer to
Appendix F; consult with Diet Tech if needed). An NGT will be placed at the end of each snack time if the patient does not consume the goal calories for that snack and the prior meal. The remainder of the calories will be provided via the NGT. The NGT will then be removed when the feeding is completed. The patient will then be given a "fresh start" to be able to achieve 100% compliance with the next meal.

The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.

If a patient has needed an NGT more than twice, in consultation with psychiatry, consideration should be made to keep the NGT in place, particularly if there has been no progress in PO feeds after the NGT is pulled.

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

The goal of the meal plan for the first day is to learn about the patient's food history, current and recent food likes, as well as reinforcers that will help engage the patient to eat

The goal of the meal plan for the next 4 days is to prevent further weight loss and to encourage patient to eat by mouth. The meals will include many likes and familiar foods. There will be less of a focus on nutritional balance.

Patients with ARFID will likely be on a behavioral plan using more frequent reinforcers for goals such as smelling, touching, tasting and/or eating small bites or a percentage of the meal.

- The meal plan consists of 3 meals + 3 snacks
- The Registered Dietician (RD) will choose the meal plan with a focus on likes and familiar foods
- Minimum of 24oz of liquid per 24-hour period.
- If initial diet order is placed after 1800, each meal that first night will be 230 ml of Ensure + 1 packet of saltine crackers or food chosen by the parent or guardian. These can be initiated and provided in ED or upon arrival to the floor. PCA will document everything consumed.
- A feeding team evaluation will occur on the first day

- **Step One:** (1500 total calories per day)
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- **Step Two:** (1800 total calories per day)
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- **Step Three:** (2100 total calories per day)
  Advance to next step based on severity of malnutrition and/or 100% PO completion

- **Step Four:**
  Increase intake by 20% or 200-300 kcal/day to a goal set by Clinical Nutrition.
  Step number continues to advance until reaching adequate intake, as determined by Clinical Nutrition.

If a patient does not finish an entire meal (breakfast, lunch, dinner), he/she will have the opportunity to take in the missed calories at the next snack by drinking a liquid nutrition supplement (Refer to
Appendix F; consult with Diet Tech if needed).

Patients with ARFID are more likely to require nasogastric tube (NGT) feedings. The decision to begin nasogastric tube (NGT) feedings is based on medical necessity as determined by the multi-disciplinary team. Once an NGT is placed, the medical team will determine if the tube should be removed or left in place.

The decision to place an NGT in a patient < 11 years old will be determined by the multi-disciplinary team.

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

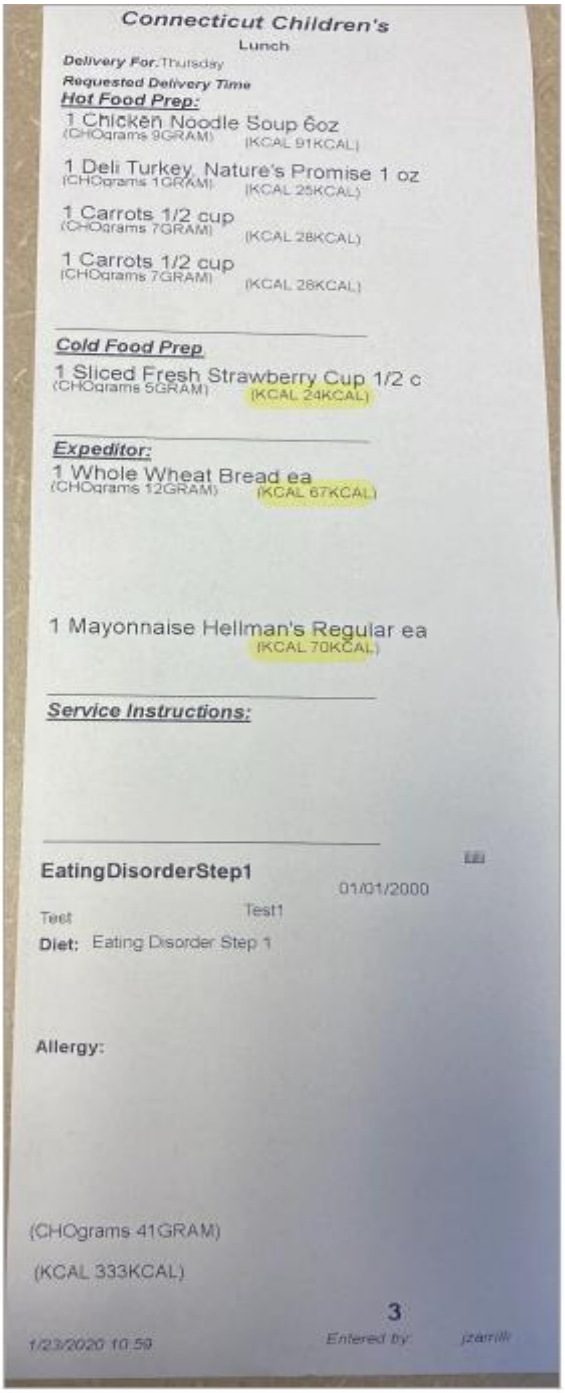
LAST UPDATED: 08.23.23

- Refer to CBORD meal ticket for total and individual food calories for each meal and snack
- For all food and beverage not consumed, calculate number of calories remaining on tray
- Give patient 1 ml Ensure (30 kcal/oz) per calorie remaining on tray
- Please save all meal and snack tickets in patient's thin chart

Example:

Patient ate all her chicken noodle soup, turkey, and carrots, but she only eats ½ her portion of strawberries and does not eat her bread or mayonnaise. How much Ensure will she need to replace the food she did not eat?

- Step 1: Use the ticket to calculate number of calories patient did not eat.
  - ½ strawberries = 12 kcal
  - Bread = 67 kcal
  - Mayonnaise = 70 kcal
  - Total = 12 + 67 + 70 = 149 kcal
- Step 2: Convert to ml Ensure (1 kcal = 1 ml Ensure)
  - Patient needs to drink 149 ml Ensure


Connecticut Children's
Lunch
Delivery For: Thursday
Requested Delivery Time
Hot Food Prep:
1 Chicken Noodle Soup 6oz
(CHOgrams 9GRAM) (KCAL 91KCAL)
1 Deli Turkey Nature's Promise 1 oz
(CHOgrams 1GRAM) (KCAL 25KCAL)
1 Carrots 1/2 cup
(CHOgrams 7GRAM) (KCAL 28KCAL)
1 Carrots 1/2 cup
(CHOgrams 7GRAM) (KCAL 28KCAL)
Cold Food Prep
1 Sliced Fresh Strawberry Cup 1/2 c
(CHOgrams 5GRAM) (KCAL 24KCAL)
Expeditor:
1 Whole Wheat Bread ea
(CHOgrams 12GRAM) (KCAL 67KCAL)
1 Mayonnaise Hellman's Regular ea
(KCAL 70KCAL)
Service Instructions:
EatingDisorderStep1
01/01/2000
Test Test1
Diet: Eating Disorder Step 1
Allergy:
(CHOgrams 41GRAM)
(KCAL 333KCAL)
3
1/23/2020 10:59 Entered by: jzarrilli

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Anorexia nervosa patients have restricted caloric intake relative to energy expenditure that leads to weight loss, plus either an intense fear of gaining weight, or behaviors that consistently interfere with weight gain. Also, there is an altered perception of one's body weight or shape, or persistent lack of acknowledgment of the seriousness of one's low body weight.

Individuals with ARFID usually do not have altered body image perceptions. They limit/restrict food intake for one of the following reasons

1. Concern about unpleasant consequences of eating, such as pain, vomiting or choking
2. Based on sensory qualities of the food
3. Seeming lack of interest in eating or food

During this hospitalization, meal time support will be developed by the medical team and then provided by sitter. Meal support strategies will be taught to the family, and meal support may be transitioned to family members to practice before discharge from the hospital.

The GOAL of meal time support is to help with: extinction of the learned avoidance behaviors, increase comfort during meal time, as well as increase the amount of food consumed during meal.

Learned "safety or avoidance behaviors"

- Eating the same limited foods - can increase sensitivities to new tastes, textures or smells
- Eating the same foods over and over - can become boring and further limit options
- Nibbling at food, taking very small bites, or excessive chewing
- Avoiding eating – can increase the worry and anxiety associated with eating

Establish routines - Keep TRYING! This takes practice and consistent exposure

- Structured meal place: sit in chair at table. Activities should be put away during meals
- Structured meal time and duration: Keep to schedule and remove meal after 30 minutes

Social Modeling

- Eat together – sitter is required to sit in the room, consider sitting at the table based on patient comfort. If family is providing meal support, they can sit at the table.
- Watch your own body language and facial expressions- try to convey positive feelings about food, model expected feeding behavior
- Do not over focus on the child's behavior - offer praise for interactions with food. Otherwise remain neutral about the patient's eating. Do not punish the patient.
- Validate the patient's feelings– Let them know all emotions/feelings are acceptable.

Think about your words

- Try to use "You can" versus "can you?"
- Offer choices: Which would you like to start with? "the apples" or "the crackers"?
- Acknowledge: "WOW, you worked hard, that wasn't easy, and you were able to take a nice sized bite of that sandwich" AVOID: "I knew you'd like it" OR "See, it was easy"
- It is generally best to avoid talking about food

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Strategies and Games that can help during meals

Get the patient's and family's input

- What strategies have worked in the past?
- Would you like to talk about something while you're eating?
- Would you like to listen to me while eating?
- Get to know the patient's interests

Distraction – Engage in conversation about topics unrelated to food

- Categories – pick a topic (animals, items found at the mall, places…) take turns coming out with items in chosen category beginning with the letters of the alphabet in order
- Going to the beach, on a picnic, or going shopping – Starting in alphabetical order take turns saying something that you would find or take with you. (A- ant, B-ball…)
- 20 questions – one person thinks of something (person, place, or object) the other person has to correctly identify and name it by asking "yes" or "no" questions. Then switch rolls (thinker becomes the question asker)
- Mad libs

For Young Children with ARFID

Be a food scientist

- What do you see? (shape, color, size)
- What does it feel like? (hard, soft, bumpy, smooth, fuzzy, wet, slippery, dry)
- What does it smell like? (sweet, sour, spicy, mild, strong)
- What does it taste like? (sweet, salty, tart, fruity, spicy)
- What does it sound like? (loud, quiet, crunchy, no sound)

Hokey Pokey: (you put the broccoli in, you take the broccoli out, you put the broccoli in and you move it all about)

Eat around the plate – use at least **3** foods (1. something always eaten, 2. something occasional eaten 3. something USED TO eat or something never eaten)

- First, use all preferred foods to teach protocol and reduce anxiety
- Use a divided plate or small bowls - have child place 2-3 preferred foods into each section
- Teach rules of even rotation (1 bite from each section of plate/bowl)
  Alternate difficult foods and easy foods - begin with reinforcing each bite of new food, progress to reinforcing following full sequence completion
    - Difficult food may first be an occasionally eaten food or a food with a slight change to taste, texture or brand
    - Gradually progress to a never eaten food
    - If unable to actually eat food, reward any attempts to move up food hierarchy (touch, kiss, lick bite)

***** You can play a game while following the above "eat around the plate" progression – such as candy land, chutes and ladders, trouble, UNO *****

- Assign a food to each color OR assign a food to each number
- Take turns playing the game, taking bites of the assigned foods

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Patient Name: _____ Date: _____

Reinforcers:

Tablet Coloring pages Arts/Crafts Games

TV/Movies Wheelchair rides Visits with friends Visits with family

Other:

Small Goals:

Touch a new food Take ____ bite(s) of a new food Eat _____% of a new food

Taste a new food Eat _____% of a familiar food Drink _____ medicine cups of a drink

Other:

Reinforcer for small goal (ex. 15 minutes of tablet)

_____

Large Goals:

Eat _____% of the meal Eat 100% of a familiar food Drink a cup of a drink

Other:

Reinforcer for Large Goal (ex. 2 hours arts/crafts with sister)

_____

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Patient Name: Date: Unit:

Date	Day	Meal Step Plan	100% Compliance	Activity Level (Assigned)	Distraction techniques that work for the patient	Comments Eating behaviors/exercise/other
	Admit		Yes / No			
	1		Yes / No			
	2		Yes / No			
	3		Yes / No			
	4		Yes / No			
	5		Yes / No			
	6		Yes / No			
	7		Yes / No			
	8		Yes / No			

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Folleto Del Paciente

Ha sido admitido en el hospital porque su médico determinó que era médicamente necesario hospitalizarlo para garantizar su seguridad y restaurar su salud física. Este protocolo se desarrolló para garantizar que su hospitalización logre estos objetivos. Si tiene alguna pregunta sobre este protocolo, hable con su enfermera o médico. Su equipo lo mantendrá actualizado sobre su progreso durante su estadía en el hospital.

Protocolo Del Paciente

Pautas Para Despertarse / Vestirse:

1. En el momento de la admisión, se le pedirá que se vista con una bata de hospital.
2. Deverá levantarse, pesarse y vestirse antes del desayuno.
3. Ropa según la determinación del equipo médico.

Pautas De Peso:

1. Se le pesará diariamente antes del desayuno, después de la primera orina en la mañana. No se usará ninguna otra ropa (es decir, ropa interior, calcetines, zapatillas o zapatos).
2. Utilizará el baño para orinar antes de que le pesen.
3. No se usarán joyas.
4. No puede comer, beber, bañarse ni cepillarse los dientes antes de pesarse.
5. Usted debe pararse en la escala de espalda hacia al peso.
6. Ni a usted ni a su familia se les informará su peso real, pero se le puede informar la tendencia general de subió, bajo o igual.

Pautas De Comidas:

1. Habrá 6 pequeñas-comidas por día. Cada día, si cumple al 100%, sus comidas avanzarán a través de un sistema, según las indicaciones de su Dietista Registrado (RD), quien se encargará de crear planes de alimentación equilibrados que satisfagan sus necesidades nutricionales. Todas las comidas serán supervisadas por el personal.
    a. Los planes de alimentación se proporcionarán a partir del primer día completo del protocolo. Si ingresa en las horas de la noche o durante la noche, se le proporcionarán galletas saladas y un suplemento nutricional en líquido como Ensure para esa hora de comida hasta la mañana siguiente. Si ingresa por la mañana o al mediodía, el equipo médico determinará si puede comenzar con las comidas de inmediato.
2. No habrá visitantes y no se permitirán actividades durante la hora de la comida, excepto el apoyo alimenticio de un miembro de la familia o el Asistente de Atención al Paciente

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

(PCA). El equipo de psiquiatría determinará la preparación de un miembro de la familia para brindar apoyo alimenticio después de la evaluación inicial, la observación y la educación con la familia.

3. El personal revisara su bandeja por exactitud antes de cada comida. No se permiten sustituciones de alimentos.

4. Tendrá 30 minutos para completar cada comida pequeña. Durante ese tiempo, la bandeja se retirará de su habitación.

5. Los horarios aproximados de comida son:

   Desayuno = 8:00am – 8:30am
   Merienda = 10:00am – 10:30am
   Almuerzo = 12:00pm – 12:30pm
   Merienda = 2:30pm – 3:00pm
   Cena = 5:00pm – 5:30pm
   Merienda = 8:30pm – 9:00pm

6. El personal registrará el consumo de alimentos en un boleto de comida.

7. No se permiten alimentos, bebidas, tazas o platos en su habitación, incluso la comida / bebida de los miembros de la familia.

8. Los planes de comidas se adelantaran según el cumplimiento y comenzarán con el desayuno a la mañana siguiente.

9. Se espera un cumplimiento del 100% con la nutrición diaria (alimentos y agua).

10. Si no puede cumplir con el 100% de cumplimiento, tendrá la oportunidad de tomar la nutrición de la comida perdida en el próximo horario de su merienda tomando un suplemento nutricional.

11. Si no puede recuperar la nutrición del suplemento nutricional en líquido, se considerará una sonda de alimentación, llamada sonda nasogástrica (NGT). Se colocará un NGT al final de cada hora de la merienda si no consume la nutrición objetivo para esa merienda y la comida anterior. El resto de la nutrición se proporcionará con un suplemento nutricional a través del NGT. El NGT se retirará cuando se complete el suplemento. Entonces tendrá un "nuevo comienzo" para poder lograr el 100% de cumplimiento con la próxima comida o merienda.

12. Harás su cama como preparación para cada comida. Si está en el nivel de actividad 1, comerá en la cama y deberá sentarse sobre la cobija. Para el nivel de actividad 2 y superior, debe comer sentado en una silla sin cobija.

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

Entorno De la Unidad:

1. La cocina familiar está prohibida.
2. Las luces deben permanecer encendidas durante el día.
3. Las cortinas de la cabecera deben mantenerse abiertas, excepto cuando se vista.
4. No se puede usar el baño durante 1 hora después de terminar las comidas o 2 horas después de terminar las comidas si hay antecedentes de forzar vomitos.
5. El uso del baño es supervisado por el personal con la puerta entreabierta cuando está en observación 1 a 1.
6. El personal medirá la producción de orina y heces después de cada uso del baño.
7. Se le colocará en observación 1 a 1 al momento de la admisión. Esto significa que habrá un miembro del personal con usted para brindarle seguridad y apoyo, y para monitorear cualquier comportamiento alimentario desordenado.

    a. Los pacientes sin conductas de forzar sus vomitos serán admitidos con observación 1 a 1 durante las comidas y durante 1 hora después de completar la nutrición si no existen criterios de exclusión.

    b. Los pacientes con conductas de forzar sus vomitos serán admitidos con observación 1a 1 durante las comidas y durante 2 horas después de que se complete la nutrición si no existen criterios de exclusión.

    c. Los pacientes tendrán una observación continua 1a1 durante cualquier momento en que esté presente una sonda NG o NJ.

    d. Se colocará a los pacientes en observación continua 1a1 durante las 24 horas del día, si cumplen con alguno de los siguientes criterios de exclusión en cualquier momento durante la hospitalización. Los criterios de exclusión incluyen:

        i. ideación suicida activa o conductas de autolesión

        ii. preocupación por el ejercicio excesivo en el entorno del tratamiento o en el hogar

        iii. preocupación por el exceso de agua potable en el entorno de tratamiento o en el hogar

        iv. alto riesgo de caídas

8. El lenguaje inapropiado o el comportamiento amenazante no es aceptable.
9. Todos los medicamentos que traiga de casa deben entregarse a su enfermera al momento de la admisión

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

10. Pedimos que las familias no hablen sobre las comidas, el peso u otros temas relacionados con la alimentación, ya que estos temas pueden generar ansiedad. El equipo de tratamiento ayudará a orientar a la familia respecto a discusiones apropiadas y al apoyo alimenticio.

Visitas:

1. La familia inmediata y el clero (persona de su preferiencia religiosa) pueden visitarlo en cualquier momento, exepto a la hora de comer, amenos que el equipo ordene lo contrario.

2. Las visitas con amigos y familiares extendidos se considerarán una vez que se logre la estabilidad médica y de acuerdo con las pautas actuales de visitas al hospital.

Actividad:

1. Todos los pacientes son admitidos en reposo en cama.

2. Se le colocará un monitor cardíaco al momento de la admisión. Esto significa que las pegatinas en su pecho medirán su frecuencia cardíaca y respiración. La duración del monitoreo cardíaco depende de su condición médica.

3. Los signos vitales (presión arterial, frecuencia cardíaca, frecuencia respiratoria y temperatura) se tomarán al menos cada 4 horas, o con mayor frecuencia, si su condición médica lo justifica.

4. Todo transporte para atención médica fuera de la unidad debe realizarse en silla de ruedas o camilla.

5. El nivel de actividad aumentará a medida que mejore el estado médico.

    a. Todos los pacientes son admitidos en la Actividad 1 (reposo en cama) y la actividad progresa a medida que el estado nutricional se estabiliza y se identificará en los niveles 1, 2 y 3 con una capacidad cada vez mayor para salir de la habitación en silla de ruedas y moverse por la habitación fuera de la cama.

    b. El equipo médico puede describir los requisitos de estabilidad médica para cada nivel de actividad en la secuencia por protocolo.
    c. El paciente y la familia serán actualizados diariamente con respecto a los avances en el nivel de actividad.

RETURN TO THE BEGINNING

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23

d. Si la familia y / o el paciente necesitan una aclaración sobre un privilegio o nivel de actividad, se les anima a consultar con el equipo médico, la enfermera o el asistente de atención al paciente (PCA).

Reforzamiento:

1. Todos los pacientes seguros serán admitidos en una habitación estándar con acceso a los artículos de comodidad habituales y las actividades de la especialista de vida infantil que están disponibles para todos los pacientes.

2. No dispositivos móviles personales

3. Se considerará un plan de comportamiento si es necesario para apoyar la estabilización de la nutrición.

4. Todas las actividades se guardarán y / o apagarán (por ejemplo, televisión, videojuegos y manualidades) antes de las comidas y antes de acostarse.

Fecha de revisión con el paciente: _____

Firma del paciente: _____
(La firma indica que el paciente recibió una copia de este folleto.)

CONTACTS: ALYSSA BENNETT, MD | CHRISTINE SKURKIS, MD | LISA NAMEROW, MD | DIANE SIEGEL, RD

LAST UPDATED: 08.23.23