**What do you Need to Success?**

**High Phosphorus Assessment Survey Tool**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Binder RX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contributing Factors Check if applies**

|  |  |
| --- | --- |
| Unable to State consequences of high phosphorus |  |
| Unable to identify high phosphorus foods / phosphate additives |  |
| Not able to state name of binder and prescribed dose |  |
| Do you chew or swallow your binder? |  |
| Not able to state reason for binder |  |
| Has binder tolerance issues ( GI upset, swallowing, taste) |  |
| Eats out frequently: # of times / week |  |
| Irregular meal pattern affecting consistency of binder dose  # of meals / # of snacks per day |  |
| Takes a long time to eat: Stagger the binders during the meal |  |
| Acknowledges intake of high phosphorus foods / excess processed foods |  |
| Forgets to take binders while at home or eating out |  |
| Not taking binders with all meals and snacks |  |
| Runs out of binders |  |
| Cannot afford binders |  |
| Inadequate dialysis Kt/V under 1.2 |  |
| Frequent missed or shortened treatments |  |
| Resides in LTC facility |  |
| Protein intake higher than needed (excess BUN) |  |
| OTC MVI with added phosphorus or herbals |  |

Intervention plan per contributing factors:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suggested medication change:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY GOAL THIS MONTH**

Changing habits can be hard. Writing down what **you** want to change can help. **You** are also more likely to succeed if **you** pick the habit **you** want to change.

Here is a list of things **you** can do that will help **you** control your phosphorus levels. Please choose the goals **you** are willing to try for this month.

○ I will learn the name of my binder and how many I should take.

○ I will remember to take my binders with all meals and snacks.

○ I will eat my meals and snacks on a more regular schedule.

○ I will take my binder with me when I eat away from home.

○ I will eat out less and cook for myself more often.

○ I will limit my portion sizes of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

○ I will eat less processed foods and eat more fresh foods.

○ I will read the ingredients labels and avoid phosphorus additives.

○ I will stop missing dialysis treatments and stay my full time.

○ I will make sure to refill my binder before I run completely out.