



Mini Nutritional Assessment MNA[®]

Last name: Mr Tanner First name: _____ Sex: M Date: _____
 Age: 72 Weight, kg: 91.6 Height, cm: 170 I.D. Number: _____

Complete the screen by filling in the boxes with the appropriate numbers.
 Add the numbers for the screen. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
 0 = severe loss of appetite
 1 = moderate loss of appetite
 2 = no loss of appetite 2

B Weight loss during the last 3 months
 0 = weight loss greater than 3 kg (6.6 lbs)
 1 = does not know
 2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
 3 = no weight loss 3

C Mobility
 0 = bed or chair bound
 1 = able to get out of bed/chair but does not go out
 2 = goes out 1

D Has suffered psychological stress or acute disease in the past 3 months
 0 = yes 2 = no 0

E Neuropsychological problems
 0 = severe dementia or depression
 1 = mild dementia
 2 = no psychological problems 2

F Body Mass Index (BMI) (weight in kg) / (height in m²)
 0 = BMI less than 19
 1 = BMI 19 to less than 21
 2 = BMI 21 to less than 23
 3 = BMI 23 or greater 3

Screening score (subtotal max. 14 points) 1 1
 12 points or greater Normal – not at risk – no need to complete assessment
 11 points or below Possible malnutrition – continue assessment

Assessment

G Lives independently (not in a nursing home or hospital)
 0 = no 1 = yes 0

H Takes more than 3 prescription drugs per day (incl. warfarin)
 0 = yes 1 = no 0

I Pressure sores or skin ulcers
 0 = yes 1 = no 1

Ref. Vellas B, Villars H, Abellan G, et al. Overview of the MNA[®] - its History and Challenges. J Nutr Health Aging 2006; 10:456-465.
 Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). J Geront 2001; 56A: M366-377.
 Guigoz Y. The Mini-Nutritional Assessment (MNA[®]) Review of the Literature - What does it tell us? J Nutr Health Aging 2006; 10:466-487.

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 For more information : www.mna-elderly.com

J How many full meals does the patient eat daily?
 0 = 1 meal
 1 = 2 meals
 2 = 3 meals 2

K Selected consumption markers for protein Intake
 • At least one serving of dairy products (milk, cheese, yogurt) per day yes no
 • Two or more servings of legumes or eggs per week yes no
 • Meat, fish or poultry every day yes no
 0.0 = if 0 or 1 yes
 0.5 = if 2 yes
 1.0 = if 3 yes 1 0

L Consumes two or more servings of fruits or vegetables per day?
 0 = no 1 = yes 1

M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?
 0.0 = less than 3 cups
 0.5 = 3 to 5 cups
 1.0 = more than 5 cups 1 0

N Mode of feeding
 0 = unable to eat without assistance
 1 = self-fed with some difficulty
 2 = self-fed without any problem 0

O Self view of nutritional status
 0 = views self as being malnourished
 1 = is uncertain of nutritional state
 2 = views self as having no nutritional problem 2

P In comparison with other people of the same age, how does the patient consider his/her health status?
 0.0 = not as good
 0.5 = does not know
 1.0 = as good
 2.0 = better 0 0

Q Mid-arm circumference (MAC) in cm
 0.0 = MAC less than 21
 0.5 = MAC 21 to 22
 1.0 = MAC 22 or greater 1 0

R Calf circumference (CC) in cm
 0 = CC less than 31 1 = CC 31 or greater 1

Assessment (max. 16 points) 1 0 0

Screening score 1 1

Total Assessment (max. 30 points) 2 1 0

Malnutrition Indicator Score
 17 to 23.5 points at risk of malnutrition
 Less than 17 points malnourished