This guide was created to help healthcare providers make informed decisions when selecting a tool to screen community-dwelling older adults for nutrition risk. The guide has information on administrators, recommendations for use, validity, and scoring for each tool.

**TOOL 1:** Seniors in the Community: Risk Evaluation for Eating and Nutrition (SCREEN©)

**Population:**
- Community-dwelling older adults (aged ≥ 55 years)

**Administrators:**
- Trained interviewers can administer SCREEN© in-person or over the phone, no anthropometric measurements required
- Older adults can self-administer SCREEN©

**Recommendations for use:**
- At initial visit with patient
- Re-administer annually, or sooner if there is concern (e.g., hospitalization)

**Learn more at:** [https://olderadultnutritionscreening.com/](https://olderadultnutritionscreening.com/)

<table>
<thead>
<tr>
<th>Version</th>
<th>Comparator</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>TRR</th>
<th>IRR</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREEN-3 (&lt;22 cut-point)</td>
<td>SCREEN-8</td>
<td>83.0%a</td>
<td>73.0%a</td>
<td>-</td>
<td>-</td>
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<tr>
<td>SCREEN-8 (&lt;38 cut-point)</td>
<td>Dietitian Nutrition Risk Rating</td>
<td>84.0%b</td>
<td>58.0%b</td>
<td>ICC = 0.84b</td>
<td>ICC = 0.79b</td>
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<tr>
<td>SCREEN-14 (&lt;50 cut-point)</td>
<td>Dietitian Nutrition Risk Rating</td>
<td>84.0%b</td>
<td>62.0%b</td>
<td>ICC = 0.83b</td>
<td>ICC = 0.83b</td>
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</tbody>
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TRR = Test-Retest Reliability; IRR = Inter-Rater Reliability; ICC = Intraclass Correlation Coefficient

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**Number of items:**
- SCREEN-14 assesses 14 items: weight change*, intentionality of weight change, perception of weight, skipping meals*, food avoidance, appetite*, vegetable and fruit intake*, protein food intake, dairy and soy intake, fluid intake*, difficulty swallowing**, difficulty chewing, meal replacement use, eating with others*, meal preparation*, meal satisfaction, and ability to grocery shop
- SCREEN-8 assesses items marked with * in the list above
- SCREEN-3 assesses items marked with † in the list above

**Risk categories:**
- **SCREEN-14:** < 50 = high nutrition risk  
  - Most informative and preferred tool for nutrition screening
- **SCREEN-8:** < 38 = high nutrition risk  
  - Quick nutrition screening tool for when time is limited
- **SCREEN-3:** < 22 = potential nutrition risk; > 22 = not likely at nutrition risk  
  - Tool helps triage patients who are likely to be at nutrition risk
  - The remaining 5 questions for SCREEN-8 are completed to confirm risk

**TOOL 2: Mini Nutritional Assessment (MNA)**

**Population:**
- Older adults (aged ≥ 65 years) in hospital, community, and other care settings

**Administrators:**
- Health professionals in hospital, community and other care settings
- Older adults can self-administer the MNA-short form using Self-MNA

**Recommendations for use:**
- At initial visit with patient
- Re-administer on a regular basis to monitor nutrition risk

**Learn more at:** [https://www.mna-elderly.com/forms/mna_guide_english_sf.pdf](https://www.mna-elderly.com/forms/mna_guide_english_sf.pdf)

<table>
<thead>
<tr>
<th>Tool</th>
<th>Comparator</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full MNA</td>
<td>Physician Assessment</td>
<td>96.0%a,b</td>
<td>98.0%a,b</td>
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<tr>
<td>MNA-short form</td>
<td>Full MNA</td>
<td>89.3%c,*</td>
<td>81.8%c,*</td>
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</tbody>
</table>

*Sensitivity and specificity values are based on the upper cut-point of 11. The MNA-SF was only validated against the full MNA, which potentially inflates the values for sensitivity and specificity.

Number of items:
- The full MNA assesses 18 items: food intake*, weight loss*, mobility*, psychological stress or acute disease*, neuropsychological problems*, measured body mass index*, living situation, prescription drug usage, pressure sores, full meals eaten daily, protein intake, vegetable and fruit intake, fluid intake, mode of feeding, self-view of nutrition status as compared to others, and measured mid-arm and calf circumference
- MNA-short form assesses items marked with * in the list above

Risk categories:
- **Full MNA**: 17-23.5 = malnutrition risk; < 17 = malnourished
- **MNA-short form**: 8-11 = malnutrition risk; 0-7 = malnourished

**TOOL 3**: Malnutrition Universal Screening Tool (MUST)

Population:
- All adults in hospital, community, and other care settings

Administrators:
- Any trained health professional can administer MUST

Recommendations for use:
- At initial visit with patient
- Re-administer on a regular basis to monitor nutrition risk

Learn more at:
- [https://www.bapen.org.uk/pdfs/must/must_full.pdf](https://www.bapen.org.uk/pdfs/must/must_full.pdf)
- [https://www.bapen.org.uk/pdfs/must/must_explan.pdf](https://www.bapen.org.uk/pdfs/must/must_explan.pdf)

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</tr>
</thead>
<tbody>
<tr>
<td>MUST</td>
<td>PG-SGA</td>
<td>69.7%a</td>
<td>75.8%a</td>
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</tbody>
</table>

PG-SGA = Patient-Generated Subjective Global Assessment

There were no statistically significant differences in sensitivity or specificity between MUST and PG-SGA.

Number of items:
- The 3 items assessed are body mass index based on measured weight and height, unintentional weight loss, and acute disease effects

Risk categories:
- **Score of 0** = low risk of malnutrition
- **Score of 1** = medium risk of malnutrition
- **Score of ≥ 2** = high risk of malnutrition

**Note**: underlined items indicate required anthropometric measurements

**Funded by the Canadian Malnutrition Task Force, a standing committee of the Canadian Nutrition Society.**