Załącznik nr 6c do zarządzenia nr 101/2025/DSOZ  
Prezesa Narodowego Funduszu Zdrowia  
z dnia 23 grudnia 2025 r.

**KARTA KWALIFIKACJI DZIECI DO LECZENIA ŻYWIENIOWEGO  
(nie dotyczy noworodków)**

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| Oznaczenie świadczeniodawcy\* | | | | | | | |  | | | Data badania (dzień/mies./rok): *………/………/……* | | | | | | |
|  | | | | | | | |  | | | Nr dok. med.:…………………….……………….. | | | | | | |
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| **DOTYCZY ŻYWIENIA:** | | | **POZAJELITOWEGO** □ | | | | | | | | | | | | | | |
|  | | | **DROGĄ PRZEWODU POKARMOWEGO** □ | | | | | | | | | | | | | | |
|  | | | **LUB ŁĄCZNIE POZAJELITOWEGO** □ | | | | | | | | | | | | | | |
|  | | | **I DROGĄ PRZEWODU POKARMOWEGO** □ | | | | | | | | | | | | | | |
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| Imię i nazwisko: .......................................................................................................... | | | | | | | | | | | | | | | | | |
| Płeć: M □ ; Ż □ | | | | | | | | | | | | | | | | | |
| Data urodzenia (dzień/mies./rok): ……/….../…….; | | | | | | | | | | | | | wiek (lata, mies.): ………………… | | | | |
| Masa ciała: ………… kg; | | | | centyle: ………….. | | | | | | | | | |  | | | |
| Wysokość ciała: ….……. cm; | | | | centyle: …………... | | | | | | | | | | | | |  |
| Masa-do-długości (wysokości) dla dzieci 2–5 lat (WHO Child Growth Standards): | | | | | | | | | | | | | | | | | |
| centyle: ................ | | | | | | | | | | | |  | | | | | |
| BMI: ……………; | | | | | | | | | | | | centyle: ………...... | | | | | |
| Obwód głowy: ................ cm; | | | | | | centyle: ............... (dotyczy niemowląt) ............. | | | | | | | | | | | |
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| **UWAGA! należy stosować siatki wzrastania wg:** | | | | | | | | | | | | | | | | | |
| 1. Kułaga Z. i wsp. Standardy Medyczne 2015; 12 (1) Suplement 1 **lub**: | | | | | | | | | | | | | | | | | |
| 2. http://www.who.int/growthref/en/ **lub** | | | | | | | | | | | | | | | | | |
| 3. Inne: | | | | | | | | | | | | | | | | | |
| ..................................................................................................................................................... | | | | | | | | | | | | | | | | | |
| (proszę wpisać inne źródło) | | | | | | | | | | | | | | | | | |
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| ROZPOZNANIE (ICD 10): | | | | | | | | | | | | | | | | | |
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| UZASADNIENIE dla ROZPOCZĘCIA leczenia żywieniowego: | | | | | | | | | | | | | | | | | |
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| **Uwaga:** Opracowane na podstawie „Standardów leczenia żywieniowego w Pediatrii 2017” – publikacja Polskiego Towarzystwa Żywienia Klinicznego Dzieci, Polskiego Towarzystwa Gastroenterologii, Hepatologii i Żywienia Dzieci oraz Polskiego Towarzystwa Neonatologicznego | | | | | | | | | | | | | | | | | |
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| Planowanie żywienia: | | | | | | | | | | | | | | | | | |
| □ **pozajelitowego**: | | □ całkowitego; | | | | | | | | □ częściowego; | | | | | | □ immunomodulacyjnego | |
| □ **drogą przewodu pokarmowego**: | | | | | | | □ całkowitego; | | | | | | | | | □ częściowego | |
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| **OKREŚLENIE 100 % DZIENNEGO ZAPOTRZEBOWANIA ENERGETYCZNEGO** | | | | | | | | | | | | | | | | | |
| **U LECZONEGO PACJENTA: ……………………….. kcal (kJ)** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **UWAGA: Orientacyjne potrzeby energetyczne u dzieci, uwzględniające podaż białka** | | | | | | | | | | | | | | | | | |
| **(CAŁKOWITE):** | | | | | | | | | | | | | | | | | |
| **wiek 0–1 lat:** | **90–100 kcal/kg mc./dobę** | | | | | | | | | | | | | | | | |
| **wiek 1–7 lat:** | **75–90 kcal/kg mc./dobę** | | | | | | | | | | | | | | | | |
| **wiek 7–12 lat:** | **60–75 kcal/kg mc./dobę** | | | | | | | | | | | | | | | | |
| **wiek12–18 lat:** | **30–60 kcal/kg mc./dobę** | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | |
| ZALECONA podaż drogą przewodu pokarmowego – % Dziennego Zapotrzebowania Energetycznego: | | | | | | | | | | | | | | | | | |
| 0% □ ; < 50% □ ; > 50% □ | | | | | | | | | | | | | | | | | |
| ZALECONA podaż drogą pozajelitową – % Dziennego Zapotrzebowania Energetycznego: | | | | | | | | | | | | | | | | | |
| 0% □ ; < 50% □ ; >50 % □ | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| W planach włączenie do programu domowego żywienia: | | | | | | | | | | | | | | | | | |
| pozajelitowego | | | | | □ TAK | | | | | | | | | | □ NIE | | |
| drogą przewodu pokarmowego | | | | | □ TAK | | | | | | | | | | □ NIE | | |
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| Uwagi: | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | Nadruk lub pieczątka  zawierająca imię i nazwisko, numer  prawa wykonywania zawodu oraz podpis lekarza | | | | | | | | | |
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| \*Pieczęć/nadruk/naklejka świadczeniodawcy zawierająca nazwę, adres, NIP, REGON | | | | | | | | | | | | | | | | | |
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