

091506T4NUT

NUTRITION AND DIETETICS LEVEL 6

MED/OS/NUD/CR/03/6

Apply Principles of Human Nutrition

July/Aug 2025



**TVET CURRICULUM DEVELOPMENT, ASSESSMENT AND CERTIFICATION
COUNCIL (TVET CDACC)**

PRACTICE

ASSESSMENT

Titration

Urinalysis

INSTRUCTIONS TO CANDIDATE:

Ani is a 30-year-old female who is an accountant with a busy schedule. She has recently been experiencing fatigue, elevated heartbeat of 120 beats per minute, sleep apnea and shortness of breath after doing any physical activity. Her eating habits include intake of takeout meals high in fat, sodium and sugary snacks. Her assessment data is as follows:

- Weight: 80kgs
- Height: 155 cm
- Blood pressure: 145/100 mmHg
- Triglycerides: 170Mmol/L
- Random blood sugar: 7mmol/L

You are a nutritionist in a health facility that Ani has visited for assistance.

1. You are required to perform the following tasks:
 - a. Interpret previous biochemical data using information provided in appendix 1.
 - b. Conduct clinical assessment for blood pressure and edema
 - c. Conduct dietary assessment using food frequency questionnaire provided in appendix 2.
 - d. Provide nutrition counseling on healthy eating habits for the patient using a food pyramid guide.
 - e. Document in the client visit form provided in appendix 3.
2. You have been provided with the following resources for the practical task:
 - Blood pressure machine
 - Pre-selected female client
 - Scientific calculator
 - Food pyramid guide
 - 2 Foolscape
 - Fully functioning skills lab
 - Pen

NB: The preselected client to repr

Appendix 1: BIOCHEMICAL DATA RANGES

Random blood glucose

Range	mg/dL	mmol/L	Diagnosis
Normal	< 140	< 7.8	Healthy random glucose level
Prediabetes	140–199	7.8–11.0	Elevated risk for diabetes
Diabetes	200+	11.1+	Confirmed diagnosis of diabetes

Triglycerides levels

Range	mg/dL	mmol/L	Interpretation
Normal	Less than 150	< 1.7	Healthy range
Borderline High	150–199	1.7–2.2	Slightly elevated
High	200–499	2.3–5.6	Increased risk
Very High	500 or more	> 5.6	May require medical treatment

APPENDIX 2: FOOD FREQUENCY QUESTIONNAIRE**7 DAY FOOD FREQUENCY QUESTIONNAIRE**

Instructions: document the frequency of consumption of the following foods in the last one week.

	Tick where appropriate (✓)								
	Once	Twice	Thrice	Four times	Five times	Six times	Daily	Never	Source
CEREALS/CARBOHYDRATES/ STARCH									
Ugali									
Uji (Fermented porridge)									
Uji (Unfermented porridge)									
Rice									
Githeri									
White Bread									
Whole meal bread									
Roasted Maize									
Boiled Maize									
WHITE ROOTS AND TUBERS									
Cassava									
Irish potatoes									
Yams									
Arrow Roots									
VITAMIN A RICH VEGETABLES AND TUBERS									
Sweet potatoes									
Carrots									
Pumpkins									
DARK GREEN LEAFY VEGETABLES									
Spinach									

Kales									
Cowpea leaves (kunde)									
Pumpkin leaves									
Black night shade (managu)									
OTHER VEGETABLES									
Cabbage									
Tomatoes									
FRUITS									
Paw paws									
Mangoes									
Watermelons									
Bananas									
Pineapples									
Avocadoes									
Citrus Fruits									
Plums									
Guavas									
Others (Please specify)									
MEATS									
Beef									
Chicken									
Mutton									
Kidney									
Chicken									
Processed meats e.g. smokies, sausages)									
FISH AND SEA FOOD									

Tilapia									
Nile perch									
Omena									
PULSES/LEGUMES/ NUTS AND SEEDS									
Dried cow peas									
Dry Beans									
Green grams									
Lentils									
MILK AND MILK PRODUCTS									
Milk									
Yoghurt									
Mala (Fermented Milk)									
OILS AND FATS									
Margarine									
Oils									
Fats									
SWEETS									
Honey									
Sugar									
BEVERAGES, SPICES AND CONDIMENTS									
Alcohol									
Spices									
Coffee									
Tea									

APPENDIX 3: CLIENT NUTRITION CLINIC VISIT FORM

Personal Details

Full Name: _____

Date: _____

Age: _____ Height: _____ cm Weight: _____ kg

Occupation: _____

Health History

Do you have (or have had) any of the following?

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease

☐ Thyroid Problems ☐ Digestive Issues (IBS, bloating, etc.)

☐ Eating Disorder (past/present) ☐ Food Allergies/Intolerances

☐ Other (please specify): _____

Any recent surgeries or hospitalizations?

☐ No ☐ Yes → Details: _____

Current medications or supplements:

Lifestyle Habits

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

If yes, how often? _____

Physical activity:

☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active

Eating Habits

How many meals per day? _____

Snacks per day? _____

Do you skip meals? ☐ Yes ☐ No

Do you eat:

☐ Home-cooked meals ☐ Takeout/fast food ☐ Restaurant meals

Are you currently following a specific diet?

☐ No ☐ Yes → Which one: _____

Do you have any specific cravings (e.g., sweet, salty)?

Sleep & Stress

Average hours of sleep per night: ____

Do you feel rested when you wake up? ☐ Yes ☐ No