

TABLE 95e-4 CHOOSE MY PLATE: A GUIDE TO INDIVIDUALIZED DIETARY PLANNING

Dietary Factor, Unit of Measure (Advice)	Examples of Standard Portion Sizes at Indicated Energy Level		
	Lower: 1600 kcal	Moderate: 2200 kcal	Higher: 2800 kcal
Fruits, cups (Focus on fruits.)	1.5	2	2.5
Vegetables, cups (Vary vegetables.)	2	3	3.5
Grains, oz eq (Make at least half of grains whole.) ^a	5	7	10
Protein foods, oz eq (Go lean with protein.) ^b	5	6	7
Dairy, cups or oz ^c (Choose calcium-rich foods.)	3	3	3
"Empty" calories, kcal ^d	120	260	400
Sodium, mg	<2300 at all energy levels		
Physical activity, min	At least 150 min vigorous physical activity per week at all energy levels		

Note: Oils (formerly listed with portions of 5, 6, and 8 teaspoons for the lower, moderate, and higher energy levels, respectively) are no longer singled out in Choose My Plate, but rather are included in the empty calories/added sugar category with SOFAS (calories from solid fats and added sugars). The limit is the remaining number of calories in each food pattern above after intake of the recommended amounts of the nutrient-dense foods.

^aFor example, 1 serving equals 1 slice bread, 1 cup ready-to-eat cereal, or 0.5 cup cooked rice, pasta, or cooked cereal. ^bFor example, 1 serving equals 1 oz lean meat, poultry, or fish; 1 egg; 1 tablespoon peanut butter; 0.25 cup cooked dry beans; or 0.5 oz nuts or seeds. ^cFor example, 1 serving equals 1 cup milk or yogurt, 1.5 oz natural cheese, or 2 oz processed cheese. ^dFormerly called "discretionary calorie allowance." Portions are calculated as the number of calories remaining after all of the above allotments are accounted for.

Abbreviation: oz eq, ounce equivalent.

Source: Data from U.S. Department of Agriculture (<http://www.Choosemyplate.gov>).

to healthier dietary patterns and identifies food groups eaten in excess of recommendations or in insufficient quantities. For persons on therapeutic diets, assessment against food-exchange lists may be useful. These include, for example, American Diabetes Association food-

exchange lists for diabetes and the Academy of Nutrition and Dietetics food-exchange lists for renal disease.

NUTRITIONAL STATUS ASSESSMENT

Full nutritional status assessment is reserved for seriously ill patients and those at very high nutritional risk when the cause of malnutrition is still uncertain after the initial clinical evaluation and dietary assessment. It involves multiple dimensions, including documentation of dietary intake, anthropometric measurements, biochemical measurements of blood and urine, clinical examination, health history elicitation, and functional status evaluation. Therapeutic dietary prescriptions and menu plans for most diseases are available from most hospitals and from the Academy of Nutrition and Dietetics. **For further discussion of nutritional assessment, see Chap. 97.**

GLOBAL CONSIDERATIONS



The DRIs (e.g., the EAR, the UL, and energy needs) are estimates of physiologic requirements based on experimental evidence. Assuming that appropriate adjustments are made for age, sex, body size, and physical activity level, these estimates should be applicable to individuals in most parts of the world. However, the AIs are based on customary and adequate intakes in U.S. and Canadian populations, which appear to be compatible with good health, rather than on a large body of direct experimental evidence. Similarly, the AMDRs represent expert opinion regarding the approximate intakes of energy-providing nutrients that are healthful in these North American populations. Thus these measures should be used with caution in other settings. Nutrient-based standards like the DRIs have also been developed by the World Health Organization/Food and Agricultural Organization of the United Nations and are available on the Web (<http://www.who.int/nutrition/topics/nutrecomm/en/index.html>). The European Food Safety Authority (EFSA) Panel on Dietetic Products, Nutrition and Allergies periodically publishes its recommendations in the *EFSA Journal*. Other countries have promulgated similar recommendations. The different standards have many similarities in their basic concepts, definitions, and nutrient recommendation levels, but there are some differences from the DRIs as a result of the functional criteria chosen, environmental differences, the timeliness of the evidence reviewed, and expert judgment.