

A Practical Guide Book

Weight Loss

Assess, Prescribe, and Monitor



Weight Loss Recommendation

Clinical Overview

Obesity is a common chronic condition caused by an imbalance between energy intake and energy expenditure, influenced by lifestyle, environment, and behavior. It is associated with increased risk of many health problems, including diabetes, hypertension, cardiovascular disease, and reduced quality of life.

Dietitians play an essential role in obesity management by providing:

- ✔ Nutrition Education
- ✔ Individualized Meal Planning
- ✔ Practical Lifestyle Guidance

1. Assessment & Screening

1.1 Body Mass Index (BMI)

BMI is calculated as: weight (kg) ÷ height (m²) and is used to classify weight status in adults.

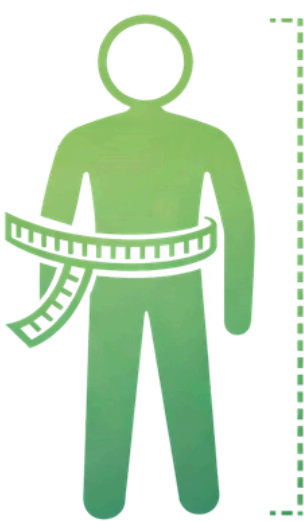
 BMI (kg/m ²): >18.5 Classification: UnderWeight Disease Risk:	 BMI (kg/m ²): 18.5–24.9 Classification: Normal Weight Disease Risk: Low
 BMI (kg/m ²): 25.0–29.9 Classification: Overweight Disease Risk: Increased	 BMI (kg/m ²): 30.0–34.9 Classification: Obesity Class I Disease Risk: High
 BMI (kg/m ²): 35.0–39.9 Classification: Obesity Class II Disease Risk: Very High	 BMI (kg/m ²): ≥40.0 Classification: Obesity Class III Disease Risk: Extremely High

1.3 Waist-to-Height Ratio (WtHR)

WtHR= Waist circumference (cm) ÷ Height (cm)

WtHR is a simple, practical indicator of obesity-related health risk, especially for abdominal fat.

 Male	 Female	Healthy Risk
≤0.95	≤0.80	Low Risk
0.96–1.0	0.81–0.85	Moderate Risk
≥1.0	≥0.85	High Risk



1.2 Waist Circumference (WC)

WC assesses central adiposity and cardiometabolic risk:

Sex	Increased Risk	Substantially Increased Risk
 Men	≥94 cm	≥102 cm
 Women	≥80 cm	≥88 cm

1.4 Ideal Body Weight (IBW)

To calculate **Ideal weight**, you can use the following equations:

Devine Formula (Most commonly used)	
 Men	50 + 2.3 x (height in inches – 60)
 Women	45.5 + 2.3 x (height in inches - 60)

Factors x Height Method:	
BMI (kg/m ²)	Factors
25-39.9	22
≥40.0	24.9

Clinical Practice Note: The “factor × height” method represents a clinical estimation approach that may be used for rapid assessment in practice settings.

1.5 Adjusted Body Weight (Adj BW)

Used when a patient is **obese (BMI ≥30)** to avoid overestimating caloric needs if using actual body weight:



Adj BW= (Wt-IBW) x 0.25+IBW

For Patients with **BMI ≥50**



Adj BW= (Wt-IBW) x 0.40+IBW

1.6 Medical History & Comorbidities

Assessment includes obesity-related comorbidities such as type 2 diabetes, hypertension, dyslipidemia, cardiovascular disease, and osteoarthritis. Knowing comorbidities helps determine the patient’s obesity-related health risk level.

Disease	Associated Risk	Nutrition Implication
Type 2 Diabetes	Hyperglycemia, insulin resistance, cardiovascular complications	Monitor carbohydrate intake, track glucose
Hypertension	Stroke, heart attack, kidney disease	Reduce sodium intake, monitor Blood Pressure
Dyslipidemia	Atherosclerosis, coronary artery disease	Reduce saturated fat, monitor lipid profile
Cardiovascular Disease	Arrhythmia, heart attack, reduced exercise tolerance	Heart-healthy diet, monitor sodium & fats
Obstructive Sleep Apnea (OSA)	Daytime sleepiness, hypertension, arrhythmias	Support weight reduction, consider dietary triggers
Osteoarthritis / Joint Pain	Reduced mobility, higher fall risk	Adequate protein & calcium, anti-inflammatory diet

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2. Goal Setting & Nutrition Prescription

2.1 Weight Loss Targets

✓ A clinically meaningful goal is 5–10% reduction in initial body weight over 3–6 months, associated with significant metabolic improvements.

2.2 Energy Requirement Equations

Common predictive equations used in clinical practice:

Mifflin–St Jeor Equation for Obese Patients:

 Men	$(10 \times \text{weight kg}) + (6.25 \times \text{height cm}) - (5 \times \text{age}) + 5$
 Women	$(10 \times \text{weight kg}) + (6.25 \times \text{height cm}) - (5 \times \text{age}) - 161$

Quick Method: Weight × Factor

BMI (kg/m ²)	Factors
25–30	25kcal/IBW
≥30	22kcal/Adj BW OR 11–14kcal/kg (Actual weight)

Clinical Practice Note: When more than one factor applies, selection should be guided by metabolic status, physical activity level, and phase of weight management.

Practice Tip: Use lower energy factors in sedentary patients or those with metabolic complications, and higher factors when activity is greater or weight loss has plateaued. Reassess after 2–4 weeks.

2.3 Physical Activity Factors

			
Activity Level	Low (sedentary)	Intermediate (some regular exercise)	High (regular activity or demanding job)
Factor	1.3	1.5	1.7

2.4 Energy Deficit and Expected Weight Change

A daily deficit of **500–800 kcal** is recommended.
≈ 7,700 kcal ≈ 1 kg fat (theoretical); actual weight loss is non-linear and influenced by metabolic adaptation, body composition, and adherence.

2.5 Macronutrient Distribution

 **Carbohydrates:** 45–55%
 **Protein:** 20–30%
 **Fat:** 20–35%
Protein factors: **1.2–2.0 g/kg IBW**, with ↑ Higher needs with high PA, energy restriction, older age, or when preserving lean mass. Adjust for renal function, tolerance, and total energy intake.

2.6 Recommended Food Patterns (New Guideline)

Use evidence-based approaches for weight loss and cardiometabolic health; individualize based on medical status, culture, and long-term sustainability.



DASH Diet

For hypertension/cardiometabolic risk; emphasizes fruits, vegetables, whole grains, low-fat dairy, lean protein, and limits sodium, saturated fat, and added sugars



Mediterranean Diet

For cardiometabolic health and long-term weight management; emphasizes plant foods, whole grains, legumes, nuts, olive oil, moderate fish/poultry, and limits red/processed meats

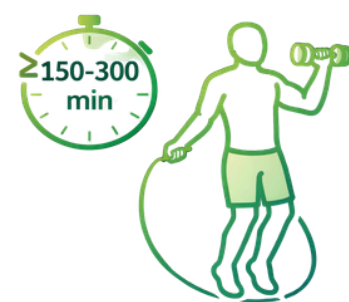


Healthy Plate Model

Practical portion guide: ½ non-starchy vegetables, ¼ lean protein, ¼ whole grains/starchy vegetables, with healthy fats in moderation

3. Behavior & Lifestyle Interventions

3.1 Physical Activity



≥150–300 minutes/week of moderate-intensity aerobic activity, with resistance training 2–3 times/week.

3.2 Sleep & Stress Management



Assess sleep and stress at each follow-up. Promote 7–9 hours of sleep and address chronic stress to support metabolic health

3.3 Monitoring Tools

By guide individualized counseling, and support sustainable behavior change. These may include:

*Food records *Physical activity logs *Waist circumference measurements *Selected digital health applications

Prioritize non-weight indicators of progress, such as improvements in dietary patterns, physical activity, metabolic markers, and overall lifestyle habits.

3.4 Behavioral Strategies

Implement evidence-based behavioral strategies, including self-monitoring, goal setting, problem solving, stimulus control, cognitive restructuring, and motivational interviewing.



Apply **Motivational interviewing** by using open-ended questions, reflecting patient statements without judgment, supporting patient autonomy, and avoiding imposed changes.



Address **Negative self-talk** by reframing thoughts into realistic, non-judgmental messages and encouraging flexible (non-perfectionist) eating.



Focus on **Gradual change**: set only 1–2 SMART behavioral goals per session. Do not attempt to change multiple behaviors at once.



Ensure **Goals must target behaviors**, not body weight, and be documented and reviewed at the next visit.

* Patient-centered counseling prompts, such as :

"What change feels most achievable for you right now?"
"How important is this goal on a scale from 1–10?"

*Approved goal examples:

Consume vegetables at ≥2 meals/day.
Replace sugar-sweetened beverages with water ≥5 days/week.
Walk ≥150 minutes/week.

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4. Red Flags & Referral



Red flags require closer monitoring:

- 🚩 Signs of disordered eating or eating disorders
- 🚩 Failure to respond to nutrition intervention
- 🚩 Severe dietary restriction or rapid unintended weight loss
- 🧠 Psychological distress impacting adherence
- 📉 Worsening obesity-related comorbidities

Referral to Other Healthcare Professionals

Referral to other healthcare professionals should be considered when nutrition alone is insufficient or when clinical complexity is present.

👉 **Bariatric Surgery:** Consider referral for individuals with BMI ≥ 40 kg/m² or BMI ≥ 35 kg/m² with comorbidities who do not respond to lifestyle intervention.

🧠 **Mental Health Services (Psychiatry / Psychology):** Refer when disordered eating, psychological distress, or mental health conditions affect adherence or safety.

💊 **Pharmacy:** Refer for medication review and support with anti-obesity pharmacotherapy when indicated.

🚶 **Physical Therapy:** Refer when mobility limitations or joint pain limit physical activity.

How NutriCare Helps You Apply These Recommendations

STEP 1

Assessment & Screening

Know your patient's health status and obesity risk category through the NutriCare calculator, with automatic classification based on key indicators and calculations (e.g., BMI, IBW, AdjBW).



STEP 2

Goal Setting & Nutrition Prescription

Initiate the meal plan by defining nutritional requirements using different approaches within NutriCare (e.g., Harris–Benedict, Mifflin–St Jeor, quick methods).



STEP 3

Behavior & Lifestyle Interventions

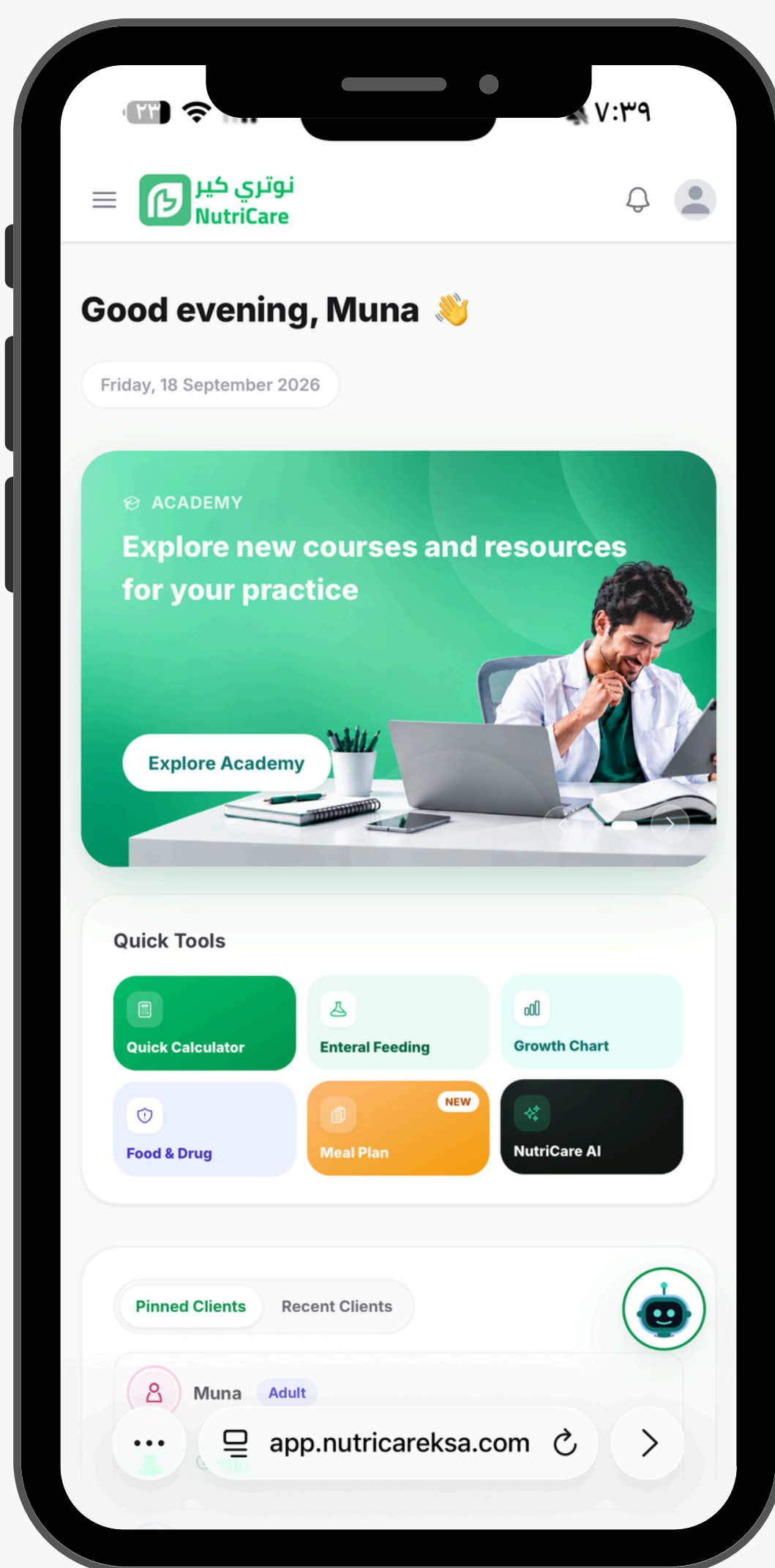
Share educational materials with your patient to support lifestyle strategies and consistent counseling, while documenting behavior-focused goals.



STEP 4

Monitoring Tools

Track patient progress over time through weight tracking and follow-up history, enabling timely plan adjustments and clear documentation.



Try it now!

