



PEDIATRIC EVALUATION

NAME _____

NUMBER _____

DEMOGRAPHICS

| | | |
|-------------------|------------------------|-----------------------|
| PATIENT NAME | ADDRESS/CITY/STATE/ZIP | TELEPHONE |
| DATE OF BIRTH | AGE/SEX/RACE | NICKNAME |
| EMERGENCY CONTACT | ADDRESS/CITY/STATE/ZIP | TELEPHONE (DAY-NIGHT) |
| MOTHER | ADDRESS/CITY/STATE/ZIP | TELEPHONE (DAY-NIGHT) |
| FATHER | ADDRESS/CITY/STATE/ZIP | TELEPHONE (DAY-NIGHT) |
| PHYSICIAN | ADDRESS/CITY/STATE/ZIP | TELEPHONE |
| HOSPITAL | ADDRESS/CITY/STATE/ZIP | DATES OF STAY |
| PARENTS EMPLOYER | ADDRESS/CITY/STATE/ZIP | TELEPHONE |
| REFERRAL SOURCE | ADDRESS/CITY/STATE/ZIP | TELEPHONE |

BILLING

| | |
|----------------------------|---|
| SOCIAL SECURITY NO. | AGENCY NO. |
| MEDICARE NO. | MEDICAID NO. |
| OTHER INSURANCE | GROUP NAME |
| NUMBER | |
| PRIMARY PAYOR | _____ MEDICARE _____ MEDICAID _____ OTHER INSURANCE |
| INSURED'S NAME | RELATION TO PT. EMPLOYER |
| STUDENT _____ YES _____ NO | GRADE _____ |
| SCHOOL | |

CLINICAL DATA

| | | |
|--------------------------------------|----------|-----------------|
| PRIMARY DX | ICD-9 | ONSET DATE |
| SECONDARY DX | ICD-9 | ONSET DATE |
| OTHER DX | ICD-9 | ONSET DATE |
| RELEVANT SURGERY | ICD-9 | DATE |
| BIRTH RELATED? _____ YES _____ NO | | |
| ACCIDENT RELATED? _____ YES _____ NO | | |
| DATE PLAN ESTABLISHED | ADM DATE | DATE CARE BEGAN |

SOCIOECONOMIC PROFILE

PRIMARY CAREGIVER

NAME _____

RELATIONSHIP _____ PARENT _____ FRIEND/RELATIVE

_____ HIRED ATTENDANT _____ OTHER (Specify) _____

_____ WILLING _____ HESITANT _____ UNWILLING

_____ NOT PAID _____ PAID

_____ AVAILABLE AS NEEDED _____ LIMITED AVAILABILITY

HEALTH: _____ GOOD _____ FAIR _____ POOR

RESIDENCE/ LIVING ARRANGEMENT/ SAFETY

_____ OWN HOME _____ ANOTHER'S HOME

SIBLINGS (NAME/AGE) _____

SAFE ENVIRONMENT _____ UNSAFE (Specify) _____

INTERCOM _____ SMOKE DETECTOR _____

IS ENVIRONMENT SUITABLE FOR TYPE, AMOUNT, LEVEL OF CARE ORDERED?

_____ YES _____ NO

ADDITIONAL INFORMATION _____

NUTRITION

TYPE OF DIET: _____ REG _____ OTHER (Specify) _____

FORMULA (TYPE/AMT. FREQ.) _____

INFUSION THERAPY _____ NO _____ YES (Describe) _____

FEEDING TUBE: _____ NO _____ YES (Describe) _____

FOOD ALLERGY: _____ NO _____ YES (Specify) _____

NO. OF MEALS/DAY _____ FAVORITE MEAL _____

LIKES _____

DISLIKES _____

ADEQUATE FOOD INTAKE _____ YES _____ NO

ADEQUATE FLUID INTAKE _____ YES _____ NO

DESCRIBE NUTRITIONAL HABITS _____

HOMEBOUND STATUS/ AMBULATION

ASSISTANCE REQUIRED: _____ MIN _____ MOD. _____ MAX.

CONFINED TO BED: _____ NO _____ YES

REQUIRES HUMAN ASSISTANCE TO AMBULATE: _____ NO _____ YES

WHEELCHAIR/CANE/WALKER USE: _____ NO _____ YES

OXYGEN USE _____ NO _____ YES OTHER DEVICE _____

FINANCIAL INFORMATION

_____ SALARY INCOME _____ SOCIAL SECURITY/MEDICAID

_____ INCOME ADEQUATE _____ INADEQUATE

OTHER AGENCY ASSISTING PATIENT (CONTACT IF PHONE)



NAME _____

NUMBER _____

PEDIATRIC EVALUATION

CLINICAL INFORMATION /HISTORY

PERTINENT HISTORY OF PRESENT ILLNESS _____

| | | | |
|---|--------------------|---------|--------------------|
| PAST ILLNESS (Include Mumps, Measles, Chicken Pox, Flu, Scarlet Fever, Whooping Cough) | DATE OF OCCURRENCE | SURGERY | DATE OF OCCURRENCE |
|---|--------------------|---------|--------------------|

ALLERGIES: _____ NO _____ YES (Specify) _____

IMMUNIZATIONS: _____ CURRENT _____ NEEDS (Specify) _____

PERTINENT FAMILY HISTORY _____ (DPT, TB, Rubella, Polio, Hib)

_____ TB TEST DATE/RESULTS _____

| | | | | |
|-----------------------|------------------------|-----|-------|--------|
| MEDICATION/DOSE/ROUTE | EQUIPMENT AND SUPPLIES | Has | Needs | Source |
|-----------------------|------------------------|-----|-------|--------|

SENSORY SYSTEM REVIEW

VISION _____ NORMAL _____ ABNORMAL _____

HEARING _____ NORMAL _____ ABNORMAL _____

SPEECH (For Age) _____ NORMAL _____ ABNORMAL _____

SMELL _____ NORMAL _____ ABNORMAL _____

TASTE _____ NORMAL _____ ABNORMAL _____

EYEGLASSES _____ YES _____ NO _____ HEARING AID _____ YES _____ NO _____

ADDITIONAL PERTINENT INFORMATION _____

SENSORY CLINICAL FINDINGS

EYE EXAMINATION _____ NORMAL _____ ABNORMAL _____

EAR EXAMINATION _____ NORMAL _____ ABNORMAL _____

NOSE EXAMINATION _____ NORMAL _____ ABNORMAL _____

THROAT EXAMINATION _____ NORMAL _____ ABNORMAL _____

MOUTH EXAMINATION _____ NORMAL _____ ABNORMAL _____

ADDITIONAL PERTINENT INFORMATION _____

NEUROLOGICAL/ MENTAL SYSTEM REVIEW

CONSCIOUSNESS _____ NORMAL _____ ABNORMAL _____

ALERTNESS _____ NORMAL _____ ABNORMAL _____

VERBAL RESPONSES (For Age) _____ NORMAL _____ ABNORMAL _____

RESPONSE TO COMMAND _____ NORMAL _____ ABNORMAL _____

MEMORY (For Age) _____ NORMAL _____ ABNORMAL _____

SLEEP PATTERNS _____ NORMAL _____ ABNORMAL _____

SEIZURES _____ NO _____ YES _____

NAPS _____ NO _____ YES _____

NAP TIMES _____

BEDTIME _____

ADDITIONAL PERTINENT INFORMATION _____

NEUROLOGICAL/MENTAL CLINICAL FINDINGS

ORIENTATION _____ P.P.T. _____ NORMAL _____ ABNORMAL _____

PUPIL RESPONSES _____ LEFT _____ NORMAL _____ ABNORMAL _____

RIGHT _____ NORMAL _____ ABNORMAL _____

GRIP _____ LEFT _____ NORMAL _____ ABNORMAL _____

RIGHT _____ NORMAL _____ ABNORMAL _____

REFLEXES _____ LEFT _____ NORMAL _____ ABNORMAL _____

RIGHT _____ NORMAL _____ ABNORMAL _____

CO-ORDINATION _____ NORMAL _____ ABNORMAL _____

BALANCE _____ NORMAL _____ ABNORMAL _____

PAINSTIMULI RESPONSE _____ NORMAL _____ ABNORMAL _____

OTHER _____ NORMAL _____ ABNORMAL _____

ADDITIONAL PERTINENT INFORMATION _____

GENITOURINARY/ELIMINATION

TOILET TRAINED _____ NO _____ YES _____

DIAPERS _____ NO _____ YES _____

FOLEY CATHETER _____ NO _____ YES _____

COLOSTOMY _____ NO _____ YES _____

HERNIA _____ NO _____ YES _____

WORDS FOR ELIMINATION _____

DESCRIBE TOILET HABITS _____

GROWTH AND DEVELOPMENT

PHYSICAL DEVELOPMENT _____ NORMAL _____ ABNORMAL _____

MOTOR DEVELOPMENT _____ NORMAL _____ ABNORMAL _____

NEUROLOGICAL DEVELOPMENT _____ NORMAL _____ ABNORMAL _____

HEAD CIRCUMFERENCE (INFANT) _____

HEIGHT _____ WEIGHT _____

DESCRIBE DEVELOPMENTAL DELAYS/ABNORMALITIES _____

305-878-5940
SAMPLE

COMPREHENSIVE PEDIATRIC NURSING ASSESSMENT

DATE OF SERVICE / /

REFER TO PATIENT/CLIENT DATA MAP FOR DEMOGRAPHICS.

TIME IN OUT

| PERTINENT BACKGROUND INFORMATION | VITALS/ALLERGIES | | | | | | | | | | | | |
|---|--|------|---------|------|---------|-------|--|--|--|------|--|--|--|
| WELL CHILD CARE FREQUENCY (if applicable) _____ PEDIATRICIAN _____ PHONE _____ CLINIC _____ DATE LAST CONTACTED <u> </u> / <u> </u> / <u> </u> DATE LAST VISITED <u> </u> / <u> </u> / <u> </u> CHIEF COMPLAINT- _____ PRESENT ILLNESS/NURSING DIAGNOSIS: _____ DISABILITIES: _____ RECENT HOSPITALIZATION? <input type="checkbox"/> No <input type="checkbox"/> Yes, dates <u> </u> / <u> </u> / <u> </u> through <u> </u> / <u> </u> / <u> </u> Reason _____ New diagnosis/condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____ OTHER PRIOR HOSPITALIZATION(S)? <input type="checkbox"/> No <input type="checkbox"/> Yes, how many times _____ Reason(s)/Dates _____ | To <u> </u> <input type="checkbox"/> O <input type="checkbox"/> R <input type="checkbox"/> Ax <input type="checkbox"/> Tymp Ht. _____ wt. _____ Resp. _____ <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. Pulse: A _____ R _____ F _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>M/P</th> <th>LYING</th> <th>S"NG</th> <th>STAWING</th> </tr> </thead> <tbody> <tr> <td>Right</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> ALLERGIES <input type="checkbox"/> None known <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Shellien <input type="checkbox"/> Eggs <input type="checkbox"/> Milk products <input type="checkbox"/> Insect bites <input type="checkbox"/> Other _____ | M/P | LYING | S"NG | STAWING | Right | | | | Left | | | |
| M/P | LYING | S"NG | STAWING | | | | | | | | | | |
| Right | | | | | | | | | | | | | |
| Left | | | | | | | | | | | | | |
| IMMUNIZATIONS (V if current) | | | | | | | | | | | | | |
| <input type="checkbox"/> DPT <input type="checkbox"/> Measles <input type="checkbox"/> Polio <input type="checkbox"/> DT <input type="checkbox"/> Mumps <input type="checkbox"/> HBV <input type="checkbox"/> MMR <input type="checkbox"/> Rubella <input type="checkbox"/> Hib <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | |

| | |
|--|---|
| Newborn screen results _____ Gestational age at birth _____ weeks Birth wt. _____ lb. _____ oz. Length _____ in. Head circumference _____ Fontanelles: <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior Umbilicus: <input type="checkbox"/> Healed <input type="checkbox"/> Hernia <input type="checkbox"/> Inverted <input type="checkbox"/> Everted NOTE: Additional newborn/infant related assessment criteria are identified by an asterisk (*) throughout the remainder of this form. | TB skin test: <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, when/results _____ Lead screening: <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, when/results _____ Other (specify) _____ |
|--|---|

| CHILDHOOD HISTORY (H-history of; N-negative; P-present problem) | | | | EYES/EARS | | | |
|---|---|---|---|------------------------|---|---|---|
| CONDITION | H | N | P | CONDITION | H | N | P |
| * Thrush | | | | Strep throat | | | |
| *Apnea | | | | Sinusitis | | | |
| Conjunctivitis | | | | Nosebleeds | | | |
| Croup | | | | Fracture(s) | | | |
| Pica | | | | Burn(s) | | | |
| Rubella | | | | Otitis media | | | |
| Rubeola | | | | Frequent ear infection | | | |
| Scarlet Fever | | | | Tonsillitis | | | |
| Mumps | | | | Frequent sore throat | | | |
| Chickenpox | | | | Bleeding problems | | | |
| Hepatitis | | | | Rheumatic fever | | | |
| Sickle Cell | | | | Headaches | | | |
| Lead poisoning | | | | Seizures-grand mal | | | |
| HIV | | | | Seizures-petit mal | | | |
| Pneumonia | | | | Other (specify) | | | |
| Asthma | | | | | | | |
| Frequent colds | | | | | | | |

| <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="2">HEAD/NECK</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Injuries/Wounds (specify) _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Masses/Nodes: Site _____ Size _____</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (specify, incl. hx) _____</td> <td></td> </tr> <tr> <td style="text-align: right;"><input type="checkbox"/> NO PROBLEM</td> <td></td> </tr> </tbody> </table> | HEAD/NECK | | <input type="checkbox"/> Injuries/Wounds (specify) _____ | | <input type="checkbox"/> Masses/Nodes: Site _____ Size _____ | | <input type="checkbox"/> Other (specify, incl. hx) _____ | | <input type="checkbox"/> NO PROBLEM | | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="2">EYES</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Glasses</td> <td><input type="checkbox"/> Contacts: (R / L)</td> </tr> <tr> <td><input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/> Blurred vision</td> </tr> <tr> <td><input type="checkbox"/> Infections _____</td> <td><input type="checkbox"/> Prostheses: (R / L)</td> </tr> <tr> <td><input type="checkbox"/> Other (specify, incl. hx) _____</td> <td><input type="checkbox"/> Legally blind</td> </tr> <tr> <td colspan="2" style="text-align: right;"><input type="checkbox"/> NO PROBLEM</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th colspan="2">EARS</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> HOH: R / L</td> <td><input type="checkbox"/> Deaf: R / L</td> </tr> <tr> <td><input type="checkbox"/> Vertigo</td> <td><input type="checkbox"/> Tinnitus</td> </tr> <tr> <td>Infections <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency _____</td> <td><input type="checkbox"/> Hearing aid: R / L</td> </tr> <tr> <td><input type="checkbox"/> P.E. tubes present <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> <tr> <td colspan="2" style="text-align: right;"><input type="checkbox"/> NO PROBLEM</td> </tr> </tbody> </table> | EYES | | <input type="checkbox"/> Glasses | <input type="checkbox"/> Contacts: (R / L) | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Infections _____ | <input type="checkbox"/> Prostheses: (R / L) | <input type="checkbox"/> Other (specify, incl. hx) _____ | <input type="checkbox"/> Legally blind | <input type="checkbox"/> NO PROBLEM | | EARS | | <input type="checkbox"/> HOH: R / L | <input type="checkbox"/> Deaf: R / L | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Tinnitus | Infections <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency _____ | <input type="checkbox"/> Hearing aid: R / L | <input type="checkbox"/> P.E. tubes present <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Other _____ | | <input type="checkbox"/> NO PROBLEM | |
|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|------|--|----------------------------------|--|-----------------------------------|---|---|--|--|--|-------------------------------------|--|------|--|-------------------------------------|--------------------------------------|----------------------------------|-----------------------------------|---|---|--|--|--------------------------------------|--|-------------------------------------|--|
| HEAD/NECK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Injuries/Wounds (specify) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Masses/Nodes: Site _____ Size _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other (specify, incl. hx) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> NO PROBLEM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EYES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Contacts: (R / L) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Blurred vision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Infections _____ | <input type="checkbox"/> Prostheses: (R / L) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other (specify, incl. hx) _____ | <input type="checkbox"/> Legally blind | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> NO PROBLEM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EARS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> HOH: R / L | <input type="checkbox"/> Deaf: R / L | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Tinnitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Infections <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency _____ | <input type="checkbox"/> Hearing aid: R / L | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> P.E. tubes present <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> NO PROBLEM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| NOSE/THROAT/MOUTH | |
|--|--|
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Dysphagia |
| <input type="checkbox"/> Lesions | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Palate intact | <input type="checkbox"/> Hoarseness |
| Teeth present <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Masses/Tumors |
| Oral hygiene practices _____ | |
| Dentist visits: frequency _____ | |
| <input type="checkbox"/> Other (specify, incl. hx) _____ | |
| <input type="checkbox"/> NO PROBLEM | |

| | |
|---|-----------|
| PATIENT/CLIENT NAME - Last, First, Middle Initial _____ | ID# _____ |
|---|-----------|

ENDOCRINE

- Hypothyroidism Hyperthyroidism
- Fatigue Intolerance to heat/cold
- Diabetes: Onset ____/____/____
- Diet/Oral control x _____ MOS. yrs.
- Med/dose/fr,eq. _____
- Insulin/dose/freq. _____
- Hyperglycemia Hypoglycemia
- Blood sugar range _____
- Self-care/self observational tasks (specify) _____
- Other (specify incl. hx) _____

NO PROBLEM

GASTROINTESTINAL (continued)

- Constipation: Chronic / Acute / Occasional
- Lax/enema use: Type _____ Freq. _____
- Flatulence Abdominal distention: Cramping/Pain freq. _____
- Impaction Flatulence: Freq. _____
- Ascites: Girth _____ inches
- Firm/Tender X _____ quads
- Bowel Sounds: Active/Hyperactive X _____ quads
- Absent X _____ quads
- Colostomy: Sigmoid/Transverse Date ____/____/____
- Rebound / Hot / Red / Discolored

NO PROBLEM

CARDIOVASCULAR

HEART SOUNDS: Reg. Irreg. (specify) _____

- Palpitations
- Pulse deficit (specify) _____
- Edema JVD Fatigue
- Cyanosis (site) _____
- Cap refill: <3 sec. / >3 sec.
- Pulses: LDP / LPT / RDP / RPT
- Other (specify, incl. hx) _____

NO PROBLEM

GENITOURINARY

- Diapers/day _____ Toilet trained (day / night / both) (bladder / bowel / both)
- Urine: Color _____ Amt. _____ Odor _____
- Frequency _____ Burning Itching
- Enuresis; bedtime ritual _____
- Catheter type/brand: _____
- Foley Straight catheter External
- Other (specify, incl. pertinent hx) _____

NO PROBLEM

RESPIRATORY

*Chest circumference _____

- Retractions Dyspnea
- BREATH SOUNDS: Clear Crackles Wheeze Absent
- Cough: Dry / Acute / Chronic
- Productive: Thick / Thin / Difficult
- Color _____

SKIN: Temp. change Color change
Specify: _____

- Percussion: Resonant / Tympanic / Dull
- Chart lobe: R L; Lat. Ant. Post.
- O2 Sat. _____
- O2 use: _____ Umin. by Mask Nasal Trach.
- Gas Liquid Concentrator
- Other (specify, incl. hx) _____

NO PROBLEM

GENITALIA

- Circumcised Uncircumcised
- Scrotum: WNL Swollen
- Testes: Descended Undescended
- Right Left Bilateral
- Puberty Menarche, if checked, age _____ LMP _____
- Pregnancy: Gravida _____ Para _____ EDC _____
- Discharge/Drainage udne/vaginal mucus/feces
- U-Other (specify)4 incl. pertinent hx) _____

NO PROBLEM

HEMATOLOGY

- Anemia Bilirubin, results _____
- Other (specify, incl. pertinent hx) _____

NO PROBLEM

NUTRITIONAL REQUIREMENTS FOR AGE (diet) _____

MEAL PATTERNS

EATING BEHAVIORS

- Eating disorder: Anorexia Bulimia
- Other (specify) _____

APPETITE: Good Fair Poor

- Weight change: Gain / Loss _____ lb. x _____ wk./mo./yr.
- Increase fluids _____ amt. Restrict fluids _____ amt.
- Nausea/Vomiting: Frequency _____ Amt. _____

LAST BM: ____/____/____ Usual frequency _____

- Diarrhea: Black/Watery; <3x/day >3x/day
- Mucus/Pain/Foul odor/Frothy Amount _____
- Abnormal stools: Clay/Tarry/ Fresh blood - describe _____

REFLEXES: Specify N - normal, A - abnormal, NA - not applicable

- Rooting _____ Blinking _____ Moro's/Startle _____
- Sucking _____ Palmar _____ Tonic neck _____
- Orienting _____ Plantar _____ Knee jerk _____
- Babinski's _____ Stepping/Dancing _____
- Other (list with results) _____

Oriented x _____ Disoriented

Cognitive development problems:

- Concepts Logic Impaired decision-making ability
- Memory loss: Short term / Long term
- Stuporous/Hallucinations: Visual / Auditory
- Headache: Location _____ Freq. _____

*INFANT MOTOR SKILLS: Lifts head Crawls/creeps

- Rolls over: Stomach to back Back to stomach
- Sits: With assistance Without assistance
- Stands: With assistance Without assistance

PATIENT/CLIENT NAME - Last, First, Middle Initial

ID#

NEUROLOGICAL (continued)

MOTOR SKILLS: Walks Runs Jumps
 Hops Skips Balance

Motor change: Fine / Gross
 Tremors: Fine / Gross / Paralysis
 Weakness: UE / LE Location _____

HAND GRIPS: Equal / Unequal, specify _____
 Strong / Weak, specify _____

Sensory loss, specify _____
 Numbness, specify _____

COMMUNICATION PATTERNS/ABILITY, describe _____

Unequal pupils: R / L / PERRLA
 Psychotropic drug use (specify) _____

Dose/Freq. _____

Other (specify, incl. hx) _____

NO PROBLEM

PSYCHOSOCIAL

Angry Flat affect Discouraged
 Withdrawn Difficulty coping Disorganized

Recent change: Birth Death Moved
 Divorce Other (specify) _____

Suicidal: Ideation Verbalized
 Depressed: Recent Long term
 Due to (if known) _____

Substance use: Drugs Alcohol Tobacco
 Evidence of abuse: Potential Actual Verbal/Emotional
 Physical Financial

Describe objective/subjective findings _____

DESCRIBE RELATIONSHIPS WITH THE FOLLOWING:
 Parents _____
 Siblings _____
 Peers _____

CHILD CARE ARRANGEMENTS: Daycare Home
 Private sitter Daycare Family member
 Other: _____

BEHAVIOR AT DAY CARE/SCHOOL _____

USUAL SLEEP/REST PATTERN _____

SLEEPING ARRANGEMENTS
 Other (specify, incl. pertinent hx) _____

10 PROBLEM

SKIN CONDITIONS/WOUNDS (Circle all that apply.)

* Mongolian spots / Itch / Rash / Dry / Scaling
 Incision / Wounds / Lesions / Sutures / Staples
 Abrasions / Lacerations / Bruises / Ecchymosis
 Edema / Hemangiomas
 Pallor: Jaundice / Redness Turgor: Good / Poor
 Other (specify, incl. pertinent hx) _____
 Description: _____

NO PROBLEM

PAIN

*This section completed in accordance with organizational policy
 Origin _____ Onset _____
 Location _____
 Quality (i.e., burning, dull ache) _____
 Intensity level: 0 1 2 3 4 5 6 7 8 9 10

Wong-Baker FACES Pain Rating Scale

0 No Pain
 1 Hurt Little Bit
 2 Hurts Little More
 3 Hurts Even More
 4 Hurts Whole Lot
 5 Hurt Worst

Alternate Coding: 0 2 4 6 8 10

Medical Provider: _____
 Explain to the person that each face is for a person who is happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts a little more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be having to feel this bad. Ask the person to choose the face that best describes how he is feeling.

* From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M. (2001). Wong's Essentials of Pediatric Nursing, 6th ed. St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Pain management history _____
 Present pain management regimen _____
 Effectiveness _____
 Other (specify) _____

NO PROBLEM

MUSCULOSKELETAL

POSTURE _____
STRENGTH _____
ENDURANCE _____

Scoliosis, type _____
 Swollen/Painful joints, specify _____
 Fracture, location _____
 Decreased ROM, specify _____
 Other (specify, incl. pertinent hx) _____

NO PROBLEM

APPLIANCES/AIDS/SPECIAL EQUIPMENT

Crutch(es) Wheelchair Cane Walker
 Brace/Orthotics (specify) _____
 Transfer equipment: Board / Lift
 Bedside commode
 Prosthesis: RUE / RLE / LUE / LLE / Other _____
 Grab bars: Bathroom / Other _____
 Hospital bed: Semi-elec. / Crank / Spec. _____
 Overlays _____
 Oxygen: HME Co. _____
 HME Rep. _____ Phone _____
 Fire Alarm Smoke Alarm
 Equipment needs (specify) _____
 Other (specify, incl. pertinent hx) _____

NONE USED

PATIENT/CLIENT NAME - Last, First, Middle Initial _____ ID# _____

INFUSION/ ENTERAL ASSESSMENT

- Peripheral (specify) _____
- PICC (specify, size, brand) _____
- Central Midline/Midclavicular
 - Single lumen Double lumen Triple lumen
 - Date of placement _____
- X-ray verification: Yes No
- Mid arm circumference _____ in/cm
- External catheter length _____ in/cm
- Hickman Broviac Groshong Jugular Subclavian
 - Single lumen Double lumen Triple lumen
 - Date of placement _____
- Epidural catheter Tunneled Port
 - Date of placement _____
- Implanted VAD Venous Arterial Peritoneal
 - Date of placement _____
- Intrathecal Port Reservoir
 - Date of placement _____
- Medication(s) ordered (name of drug) _____
 - Dose _____
 - Route _____
 - Frequency _____
 - Duration of therapy _____
- Medication(s) ordered (name of drug) _____
 - Dose _____
 - Route _____
 - Frequency _____
 - Duration of therapy _____
- Medication(s) ordered (name of drug) _____
 - Dose _____
 - Route _____
 - Frequency _____
 - Duration of therapy _____
- Pump (type, specify) _____
- Administered by: Self Caregiver RN Other _____

Flushing protocol/frequency: (Circle all that apply)

| | | |
|---|---|---|
| ____ cc normal saline or ____ cc sterile water before/ after meds before/ after labs line maintenance | ____ cc normal saline or ____ cc sterile water before/ after meds before/ after labs line maintenance | ____ cc normal saline or ____ cc sterile water before/ after meds before/ after labs line maintenance |
|---|---|---|

Flushing protocol/frequency: (Circle all that apply)

| | | |
|--|--|--|
| ____ cc heparin-u/ml before/ after meds before/ after labs line maintenance | ____ cc heparin-u/ml before/ after meds before/ after labs line maintenance | ____ cc heparin-u/ml before/ after meds before/ after labs line maintenance |
|--|--|--|

- Dressing change: Sterile Clean
- Performed by: Self RN Cg Other _____
- Frequency (specify): _____
- Injection cap change (specify frequency): _____
- Additional comments: _____

ENTERAL FEEDINGS - ACCESS DEVICE

- Nasogastric Gastrostomy Jejunostomy
- Other (specify): _____
- Pump: (type/specify): _____
- Feedings: Bolus Continuous
- Flush Protocol (and specify): _____
- Performed by: Self RN Cg Other _____
- Dressing/Site care (specify): _____
- Additional comments: _____

PATIENT/CLIENT NAME - Last, First, Middle Initial

ID#

SKILLED CARE (wound, catheter, administration of meds, venipuncture, IV, etc.)

PATIENT/CLIENT/CAREGIVER RESPONSE

SUMMARY OF GROWTH AND DEVELOPMENT FOR AGE

PROGNOSIS/ LEARNING POTENTIAL

DISCHARGE PLANS

SUMMARY CHECKLIST

MEDICATION STATUS: Medication regimen completed/reviewed Check if any of the following were identified:
Potential adverse effects/drug reactions Ineffective drug therapy Significant side effects Significant drug interactions
Duplicate drug therapy Non-compliance with drug therapy No change Order obtained

BILLABLE SUPPLIES RECORDED? Yes No

CARE COORDINATION Physician PT OT ST SS SN Aide Other (specify)

SIGNATURE/DATES

X Patient/Client/Caregiver (if applicable)

Date / /

Complete TIME OUT (page 1) prior to signing below.

X PLTson Completing This Form (signature/title)

/ /

PATIENT/CLIENT NAME - Last, Middle Initial

ID#

DEVELOPMENTAL STAGES ASSESSMENT GUIDE

To remove for patient/client education, fold on the perforation at the left and tear.

| Stage(s) | Motor (Fine/Gross) | Social/Cognitive/Language |
|---|--|--|
| INFANCY (birth to 1 year) Needs parents or caregivers who are affectionate consistent predictable and help children trust and bond with family and friends | Birth to * <2 mos. <ul style="list-style-type: none"> Sucks on closed fist Roofing reflex (ends approx. 3 1/2 mos.) Moro reflex (ends approx. 6 wks.) Walking/Stepping reflex (ends approx. 6 wks.) | <ul style="list-style-type: none"> Responds to voices Communicates mainly by crying Quiets to holding and cuddling Reacts to loud sounds or bright patterns/objects |
| | 2 mos. <ul style="list-style-type: none"> Holds head up when lying prone May roll over Holds objects momentarily Voluntarily grasps objects Sits supported, holds head steady (within 3 mos.) | <ul style="list-style-type: none"> Smiles responsively Focuses on objects Follows people with eyes Vocalizes (other than crying) |
| | 4 mos. <ul style="list-style-type: none"> Bears weight on legs while held in lap Brings objects to mouth Rolls from front to back Reaches with arms | <ul style="list-style-type: none"> Responds to others with more vocalizing, squeals & laugh Cries when left alone and stops when familiar person returns Recognizes mom in a group Drops objects to watch others pick up and looks where it lands (5 mos.) |
| | 6 mos. <ul style="list-style-type: none"> Reaches for objects Sits with support or alone Transfers items from hand to hand Rolls over front to back, back to front Plays with hands and feet | <ul style="list-style-type: none"> Separation anxiety begins Plays peek-a-boo Turns to familiar noises Imitates speech sounds (ma-ma, da-da, etc.) |
| | 9 mos. <ul style="list-style-type: none"> Creeps, pulls to stand Can drink from cup with assistance Crawls well Firmer grasp Waves bye-bye | <ul style="list-style-type: none"> Separation anxiety continues Learns to see self as a separate person from another Plays pat-a-cake Learns the meanings of words |
| | 12 mos. * <ul style="list-style-type: none"> Climbs up and down chairs/steps Walks without assistance (varies) Bends, stoops, squats Points with index finger Babinski reflex gone by 1 yr. | <ul style="list-style-type: none"> Understands "no" Uses simple words - 2-8 words Looks at pictures, turns pages Imitates behavior Associates words with gestures Helps dress self |
| TODDLER (1-3 old) Needs experiences in caring for themselves, (e.g. feeding themselves, toilet behaviors, dressing). Needs parents who give choices within limitations and boundaries. | 18 mos. <ul style="list-style-type: none"> Pulls or pushes toy while walking Walks sideways and backwards Drinks regularly from a cup Builds small towers of blocks Tries to climb out of bed Runs, trots, climbs Plays ball Scribbles with big crayons | <ul style="list-style-type: none"> Recognizes names of major body parts Listens to stories, enjoys rhymes Enjoys singing songs/playing games Follows simple commands Understands more words than can say |
| | 2 yrs. old <ul style="list-style-type: none"> Loves to be chased Able to remove clothing Toilet training started Kicks a ball forward Enjoys dancing Turns pages one at a time Recognizes shapes Throws ball overhand Starts showing hand preference Enjoys playground activities | <ul style="list-style-type: none"> Vocabulary of over 200 words Has 2 way conversation Learns everything has a name and constantly asks "what's that?" May be aware of cause/effect but not of dangers Short attention span |
| PATIENT/CLIENT NAME - Last, First, Middle Initial | | ID# |

DEVELOPMENTAL STAGES ASSESSMENT GUIDE

To remove for patient/client education, fold on the perforation at the right and tear.

| Stage(s) | Motor (Fine/Gross) | Social/Cognitive/Language |
|---|--|--|
| TODDLER (cont'd.) (1-3 yrs. okQ) | 3 yrs. old <ul style="list-style-type: none"> • Washes/dries own hands • Learns to hold pencil in writing position • Pedals and steers tricycle well • Loves to draw with chalk and crayons • Kicks ball in intended direction • Able to do 2 activities at once | <ul style="list-style-type: none"> • Names at least four pictures in a book • Understands number concept (counting stairs) • Begins to use pronouns (1, me) • May begin asking "why" |
| PRESCHOOLER Needs parents who let children participate in family work activities Needs teachers who give children projects that they can complete to gain a sense of achievement Needs parents and teachers who correct children with logical consequences Sibling rivalry is frequent | 4-5 yrs. old <ul style="list-style-type: none"> • Learns to dress self without help • Able to express self verbally and begins to write • Able to draw pictures well by 5 yrs. old • Hops on one foot • Balances on one leg • Alternates feet when climbing stairs | <ul style="list-style-type: none"> • Egocentric • Logic is intuitive • Words have a single meaning or aspect • By 5 yrs. old can count to 10 or more objects correctly • Knows first and last name • Knows four different colors |
| SCHOOLAGE Needs experiences building creating, and accomplishing to gain a feeling of adequacy. Needs encouragement and deserved praise to achieve competence. Needs academic social, physical and work skills for healthy self esteem Needs teachers and parents who are nurturing to help children discover and develop special talents and abilities | 6-12 yrs. old <ul style="list-style-type: none"> • Learns to read and write well • Ability to express self with art improves • Participates in vigorous physical activity | <ul style="list-style-type: none"> • Early years more supervised play, older, more independent team oriented, physical activity • Deductive reasoning • Classifies by multiple dimensions • Imitates and completes tasks or school projects • Attends appropriate grade for age |
| ADOLESCENCE Needs experiences in developing ego identity including moral social and vocational identity Needs parents teachers and others who appreciate the adolescent as a unique and worthwhile individual | 13-18 yrs. old <ul style="list-style-type: none"> • Early in stage, rapid physical growth (girls usually attain increasing strength and coordination before boys) • Motor skills reach adult level | <ul style="list-style-type: none"> • Shift to abstract thinking • Shift away from egocentrism • Deductive reasoning is well developed • Cognition is adult type • Attending appropriate grade for age • Starts/Makes plan for future (college, work, etc.) |
| PATIENT/CLIENT NAME Last First Middle Initial | | ID# |



| Name: _____ | M.R. #: _____ | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|-------|------------|-------|------------|----|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Time In: _____ Time Out: _____ | Total Hours: _____ Date: _____ | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Emergency Equipment Check <input type="checkbox"/> Care Plan / MD Orders Checked <input type="checkbox"/> AmbuBag / Extra Trach on site <input type="checkbox"/> Infection Control Kit / Micro Shield <input type="checkbox"/> Last Date DME Equipment Check _____ Weight _____ lbs. _____ oz. _____ kg. | VITAL SIGNS | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Pt. ID Verified <input type="checkbox"/> Consent Received | <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">Time</th> <th style="width:10%;">Temp</th> <th style="width:10%;">Pulse</th> <th style="width:10%;">Resp. Rate</th> <th style="width:10%;">BP</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> | Time | Temp | Pulse | Resp. Rate | BP | | | | | | | | | | | | | | | | | | | | |
| Time | Temp | Pulse | Resp. Rate | BP | | | | | | | | | | | | | | | | | | | | | | |
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| NUTRITIONAL ASSESSMENT Diet: <input type="checkbox"/> NPO <input type="checkbox"/> Regular <input type="checkbox"/> Restricted / Type: _____ <input type="checkbox"/> Breast <input type="checkbox"/> Formula -Type: _____ Other: _____ Amount: _____ Frequency: _____ Fluids: <input type="checkbox"/> Restriction <input type="checkbox"/> No Restriction Nutritional Screening Risk: <input type="checkbox"/> LOW <input type="checkbox"/> MED <input type="checkbox"/> HIGH Appetite: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | CARDIOVASCULAR Heart Tones: <input type="checkbox"/> Strong <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Murmur <input type="checkbox"/> Other: _____ Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Pale <input type="checkbox"/> Dusky <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundiced Skin Temp: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Clammy <input type="checkbox"/> Hot Edema: <input type="checkbox"/> No <input type="checkbox"/> Yes Site: _____ <input type="checkbox"/> LUE <input type="checkbox"/> LLE <input type="checkbox"/> RUE <input type="checkbox"/> RLE Capillary Refill: <input type="checkbox"/> Less than 3 seconds <input type="checkbox"/> Greater than 3 seconds <input type="checkbox"/> LUE <input type="checkbox"/> LLE <input type="checkbox"/> RUE <input type="checkbox"/> FILE Peripheral Pulses: <input type="checkbox"/> Strong <input type="checkbox"/> Bounding <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Doppler <input type="checkbox"/> Absent <input type="checkbox"/> Other: _____ <input type="checkbox"/> LUE <input type="checkbox"/> LLE <input type="checkbox"/> RUE <input type="checkbox"/> RLE | | | | | | | | | | | | | | | | | | | | | | | | | |
| NEUROLOGICAL <input type="checkbox"/> Verbal <input type="checkbox"/> Non Verbal <input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Sedated <input type="checkbox"/> Comatose <input type="checkbox"/> Semi-Comatose Appropriate for Age: <input type="checkbox"/> Yes <input type="checkbox"/> No Tone: <input type="checkbox"/> Active <input type="checkbox"/> Flaccid <input type="checkbox"/> Jittery <input type="checkbox"/> Rigid Fontanel: <input type="checkbox"/> Flat <input type="checkbox"/> Soft <input type="checkbox"/> Sunken <input type="checkbox"/> Tense <input type="checkbox"/> Bulging <input type="checkbox"/> N/A Reflexes Present: <input type="checkbox"/> Suck <input type="checkbox"/> Gag <input type="checkbox"/> Grasp <input type="checkbox"/> Startle <input type="checkbox"/> Blink <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____ Seizure Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See Seizure Record | HEAD (Circle R for Right or L for Left) Face: <input type="checkbox"/> Symmetrical <input type="checkbox"/> Asymmetrical Ears: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Low R L <input type="checkbox"/> Other: _____ Eyes: Cornea: <input type="checkbox"/> Clear R L <input type="checkbox"/> Opaque R L Sclera: <input type="checkbox"/> White R L <input type="checkbox"/> Jaundiced R L <input type="checkbox"/> Hemorrhage R L Nose: <input type="checkbox"/> Patent <input type="checkbox"/> Other: _____ Mouth: <input type="checkbox"/> Unremarkable <input type="checkbox"/> Other: _____ | | | | | | | | | | | | | | | | | | | | | | | | | |
| RESPIRATORY <input type="checkbox"/> Regular <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Grunting <input type="checkbox"/> Panting <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Retractions <input type="checkbox"/> Mild <input type="checkbox"/> Deep <input type="checkbox"/> Abdominal Breath Sounds: <input type="checkbox"/> Clear <input type="checkbox"/> Rales <input type="checkbox"/> Rhonchi <input type="checkbox"/> Diminished <input type="checkbox"/> Wheeze <input type="checkbox"/> Inspiratory <input type="checkbox"/> Expiratory If other than clear indicate lobe or lobes adventitious Breath sounds auscultated: _____ Cough: <input type="checkbox"/> None <input type="checkbox"/> Productive <input type="checkbox"/> Non-Productive Secretions: <input type="checkbox"/> N/A Amount: <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large Consistency: <input type="checkbox"/> Thin <input type="checkbox"/> Thick <input type="checkbox"/> Tenacious <input type="checkbox"/> Frothy Color: <input type="checkbox"/> Clear <input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Blood tinged <input type="checkbox"/> Frank Bleeding <input type="checkbox"/> Tan <input type="checkbox"/> Apnea Monitor Alarm Setting: High _____ Low _____ Delay _____ Pulse Oximetry: <input type="checkbox"/> Continual <input type="checkbox"/> Intermittent Oxygen: _____ L/min via: <input type="checkbox"/> NC <input type="checkbox"/> Mask <input type="checkbox"/> Trach <input type="checkbox"/> Intermittent <input type="checkbox"/> Continual O2 Saturation: _____ Other: _____ | MUSCULO-SKELETAL <input type="checkbox"/> Full ROM <input type="checkbox"/> Limited ROM Comments: _____ <input type="checkbox"/> Contractures <input type="checkbox"/> Reposition q 2hrs. | | | | | | | | | | | | | | | | | | | | | | | | | |
| RESPIRATORY CARE Tracheostomy Type: _____ Size: _____ <input type="checkbox"/> Cuffed <input type="checkbox"/> Uncuffed Date last changed: _____ Changed by: <input type="checkbox"/> RN <input type="checkbox"/> MD <input type="checkbox"/> Other _____ Trach. Care: <input type="checkbox"/> 1/2 strength H ₂ O ₂ + H ₂ O <input type="checkbox"/> NS <input type="checkbox"/> Warm soapy H ₂ O Technique: <input type="checkbox"/> Clean <input type="checkbox"/> Sterile <input type="checkbox"/> Trach. Ties Changed Inner Cannula Changed: _____ (Date) using <input type="checkbox"/> clean <input type="checkbox"/> sterile technique Trach. Site: <input type="checkbox"/> Dry <input type="checkbox"/> Intact <input type="checkbox"/> Redness <input type="checkbox"/> Excoriation <input type="checkbox"/> Drainage Intervention: <input type="checkbox"/> MD notified <input type="checkbox"/> RN notified <input type="checkbox"/> Supervisor Other: _____ | SKIN CONDITION <input type="checkbox"/> Intact <input type="checkbox"/> Clear <input type="checkbox"/> Peeling <input type="checkbox"/> Rash <input type="checkbox"/> No S/S infection Wound/Decubitus site: _____ Size: _____ Drainage: _____ Type of Dressing: _____ Wound Care: _____ | | | | | | | | | | | | | | | | | | | | | | | | | |
| VENTILATOR Type: _____ Rate: _____ <input type="checkbox"/> CPAP: rate _____ TV: _____ PEEP: _____ PIP: _____ Alarm Checked / Set At: _____ High _____ Low <input type="checkbox"/> Equipment Cleaned Solution Used: _____ Hrs. / Day on Ventilator: _____ | GASTROINTESTINAL Abdomen: <input type="checkbox"/> soft <input type="checkbox"/> Tense <input type="checkbox"/> Flat <input type="checkbox"/> Distended Bowel Sounds: <input type="checkbox"/> Present <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo <input type="checkbox"/> Absent Feeding Tube: <input type="checkbox"/> N/A <input type="checkbox"/> NG <input type="checkbox"/> J Tube <input type="checkbox"/> G Tube <input type="checkbox"/> Mickey Button Feeding Tube Care: <input type="checkbox"/> 1/2 strength H ₂ O ₂ + H ₂ O <input type="checkbox"/> NS <input type="checkbox"/> Warm Soapy H ₂ O <input type="checkbox"/> Other: _____ Flushes: Solution _____, Amount _____, Frequency _____ GT Site: <input type="checkbox"/> Dry <input type="checkbox"/> Intact <input type="checkbox"/> Redness <input type="checkbox"/> Excoriation <input type="checkbox"/> Drainage <input type="checkbox"/> No S/S of Infection <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | |
| GENITO-URINARY <input type="checkbox"/> Unremarkable <input type="checkbox"/> Discharge <input type="checkbox"/> Circumcised Bladder Frequency: _____ Urine: Color _____ Odor: <input type="checkbox"/> Yes <input type="checkbox"/> No Appearance: _____ <input type="checkbox"/> Foley Cath <input type="checkbox"/> Suprapubic <input type="checkbox"/> Intermittent | INTRAVENOUS Access: <input type="checkbox"/> N/A <input type="checkbox"/> Peripheral <input type="checkbox"/> CVL <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Other: _____ Location: _____ Site Condition: <input type="checkbox"/> Intact <input type="checkbox"/> Without Redness or Swelling <input type="checkbox"/> Dressing Changed using: <input type="checkbox"/> Sterile <input type="checkbox"/> Aseptic technique <input type="checkbox"/> Transparent <input type="checkbox"/> Other: _____ <input type="checkbox"/> Bag Changed <input type="checkbox"/> Tubing Changed <input type="checkbox"/> Cap Change | | | | | | | | | | | | | | | | | | | | | | | | | |
| Irrigated / Flushed with: _____ Labs: <input type="checkbox"/> N/A Tests: _____ Site used: _____ Labs Taken to: _____ or Picked up by: _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | |

Patient _____

Week Beginning _____



**QUALITY CARE
NURSING SERVICES, INC.**

Pediatric Weekly Medication Sheet

| Medication (dose, route, freq.) | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat | Sun |
|------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | Date _____ | Date _____ | Date _____ | Date _____ | Date _____ | Date _____ | Date _____ |
| | Time Initials | Time Initials | Time Initials | Time Initials | Time Initials | Time Initials | Time Initials |

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| Order Date | | | | | | | | | | | | | | | | | | | |
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PN System 305.878.5940
SAMPLE

Allergies

Print and Sign Name _____
