

INITIAL CHECK INFORMATION MAY BE COMPLETED BY NURSE OR TECH

Identification bracelet on patient

PATIENT NAME IN FULL _____ AGE _____ DATE _____ TIME _____

SOURCE OF INFORMATION _____ NAME PREFERENCE - IF APPLICABLE _____

VITAL SIGNS - TEMPERATURE _____ TEMPERATURE TAKEN Tympanic Oral Axillary Rectal PULSE _____ RESPIRATION _____ BLOOD PRESSURE _____ mmHg

HEIGHT _____ cm WEIGHT _____ kg DATA SOURCE Weighed patient Stated weight MEASUREMENTS - ONLY REQUIRED FOR PATIENTS LESS THAN OR EQUAL TO 1 YEAR OF AGE FOC _____ cm CHEST CIRCUMFERENCE _____ cm ABDOMINAL GIRTH _____ cm

ALLERGY - MEDICATIONS NKDA **ALLERGY - OTHER** NKDA

MEDICATION ALLERGY	SYMPTOM	OTHER ALLERGY	SYMPTOM

Allergy bracelet on patient Not indicated Blood bracelet on patient Not indicated

ORIENTATION - PERSON(S) ORIENTED

ORIENTED TO: ALL OF THE FOLLOWING OR - MARK INDIVIDUALLY Intercom Visiting policies Children's Hospital Bed controls Emergency call light TV Room TV Side rails Call lights Written information given regarding children rights, ethics and process for patient complaints

Verification of height / weight / allergy information by a Licensed Nurse - SIGNATURE _____ DATE _____ TIME _____

COMMENTS _____

COMPLETED BY - SIGNATURE _____ DATE _____ TIME _____

ADMISSION ASSESSMENT - PERFORMED BY A LICENSED NURSE

MEDICATION HISTORY				
MEDICATION	DOSE	FREQUENCY	LAST TAKEN	COMMENTS

DISPOSITION OF MEDICATIONS BROUGHT FROM HOME _____

PAST MEDICAL HISTORY - INCLUDE DISEASE AND ILLNESS HISTORY, PREVIOUS SURGERY OR INJURY _____

PATIENT LABEL



Fully awake

Alert Responsive to caregivers

Other -

BEHAVIOR

Appropriate for age

Other -

FONTANEL - PATIENTS 2 YEARS OLD OR YOUNGER

SIZE DESCRIPTION

Right Pupil -

Left Pupil -

GLASGOW COMA SCALE - NOTE: SELECTION MUST BE MADE FOR EACH FIELD

Swelling

- 1 Neither eye swollen closed, both eyes able to open actively OR passively
- 2 Left eye swollen closed, unable to open
- 3 Right eye swollen closed, unable to open
- 4 Both eyes swollen closed, unable to open

Tube

- 1 No tube in place
- 2 Endotracheal tube in place
- 3 Tracheal tube in place

Left Eye

- 1 No response or eye swollen closed
- 2 Opens to pain
- 3 Opens to speech / touch
- 4 Opens spontaneously

Right Eye

- 1 No response or eye swollen closed
- 2 Opens to pain
- 3 Opens to speech / touch
- 4 Opens spontaneously

Verbal

- 1 No response, ET / ETT in place, no moaning / cry to pain
- 2 Incomprehensible, no recognizable words, moans to pain
- 3 Inappropriate, cries to pain, words used randomly
- 4 Confused, short attention span, irritable cry, inconsolable
- 5 Oriented, coos / babbles, easily comforted, appropriate cry, social smiles

COUGH REFLEX

No deficits identified Other -

GAG REFLEX

No deficits identified Other -

SWALLOW DESCRIPTION

Able to swallow Other -

MOUTH

Mucosa pink / moist Other -

TEETH

Normal for age Other -

MOTOR - MOTOR LIMB MOVEMENTS RESPONSE

APICAL Pulse regular Other -

PERIPHERAL

Pulses palpable, strong, equal bilaterally Other -

PCU - CENTRAL

Pulses palpable, strong, equal bilaterally Other -

SKIN DESCRIPTION

Color normal, warm and dry to touch, intact Other -

EDEMA - LOCATION

DESCRIPTION

PATIENT LABEL



PATIENT NAME IN FULL

AGE

DATE

TIME

BRUISES / RASH / SCAR / LESION / BIRTHMARK

TYPE	LOCATION	DESCRIPTION

INCISION

LOCATION	SITE	DESCRIPTION	DRESSING

WOUND

TYPE	LOCATION	DESCRIPTION	
		SITE	DRESSING

BRADEN Q SKIN SCORE - NOTE: SELECTION MUST BE MADE FOR EACH FIELD
IF MORE THAN 1 PRESSURE ULCER PRESENT DOCUMENT THE HIGHEST STAGE ULCER

Pressure Ulcer

- 2 I. Nonblanchable / intact; dark skin - discolored, warmth, edema, hardness
- 4 II. Partial thickness - loss of skin layers
- 6 III. Full thickness - loss thru dermis to subcutaneous tissue
- 8 IV. Deep tissue destruction to fascia, muscle, and / or bone
- 9 Unstageable
- 1 Unstable to assess
- 0 None

Sensory Perception

- 1 Completely limited - no response to painful stimuli or limited ability to feel pain
- 2 Very limited - respond to pain (moaning / restless) or sensory impaired greater than 1/2 body
- 3 Slightly limited - can't always communicate needs or sensory impaired 1-2 extremities
- 4 No impairment - responds to verbal commands, no sensory deficit

Moisture Options

- 1 Constantly moist - skin is moist almost constantly
- 2 Moist - skin is often but not always moist, linen change once / shift
- 3 Occasionally moist - skin is occasionally moist, extra linen change daily
- 4 Rarely moist - skin is usually dry, linen change routine

Activity

- 1 Bedfast - confined to bed
- 2 Chairfast - cannot bear own weight and / or must be assisted to chair
- 3 Walks occasionally - walks occasionally, spends majority of time in bed / chair
- 4 Walks frequently - walks outside of room at least twice a day

Mobility

- 1 Completely immobile - no changes body / extremity position without assistance
- 2 Very limited - unable to make frequent or significant changes independently
- 3 Slightly limited - makes slight changes, body / extremity position independently
- 4 No limitations - frequent changes in position without assistance

Nutrition

- 1 Very poor - eats 1/3 meals, poor fluid intake or NPO or on clear liquid / IV for greater than 5 days
- 2 Probably inadequate - eats 1/2 meals or receives less than optimum amount of liquid diet / tube feeding
- 3 Adequate - eats over 1/2 of most meals or on tube feeding or TPN
- 4 Excellent - eats most of every meal, never refuses meals, eats between meals

Friction / Shear

- 1 Problem - moderate / maximum assistance, frequently slides in bed / chair, constant friction / spasticity
- 2 Potential problem - requires minimum assistance, occasionally slides down bed / chair
- 3 No apparent problem - moves in bed and in chair independently

PATIENT LABEL



The Children's Hospital at Saint Francis

Saint Francis Hospital
PEDIATRICS / NEONATAL INTENSIVE CARE UNIT



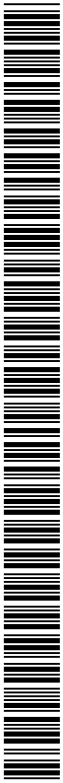


Children's Hospital at Saint Francis

PEDIATRICS / NEONATAL INTENSIVE CARE UNIT

ADMISSION HISTORY AND ASSESSMENT

PAIN - FLACC SCALE		AGE	DATE	TIME	
PAIN SCALE USED					
<input type="checkbox"/> FLACC <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Faces <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Numbered <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5					
CATEGORIES					
0	1	2	SCORING		
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw	Kicking, or legs drawn up	
LEGS	Normal position or relaxed	Uneasy, restless, tense	Arched, rigid or jerking		
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Crying steadily, screams or sobs, frequent complaints		
CRY	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Difficult to console or comfort		
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort		
RESPIRATORY / GI / GU / IV					
RESPIRATIONS	Regular, unlabored respirations	Clear, equal bilaterally	BREATHE SOUNDS		
COUGH / SECRETIONS	None	No artificial airway	AIRWAY		
ABDOMEN / GI / GU	No problems noted	No complaints of nausea, vomiting or diarrhea	NAUSEA / VOMITING / DIARRHEA / WEIGHT LOSS		
GENITALIA	Abd soft w/BS X 4 quad	No complaints of nausea, vomiting or diarrhea	TUBE / DRAIN		
DEVICE	Within normal limits	VENOUS ACCESS			
ADMISSION ASSESSMENT					
INFORMANT	REASON FOR ADMIT				
IMMUNIZATIONS	Current	IMMUNIZED IN LAST 72 HOURS	IF YES - GIVE DATE		
RECEIVED CHEMO IN LAST 90 DAYS	Other	TRANSFUSED WITHIN LAST 90 DAYS	IF YES - GIVE DATE		
SAFETY-1X INTERVENTION - REVIEWED WITH CAREGIVER	None	SAFETY - ONGOING	ID bracelet on patient and legible -		
SAFETY - ONGOING	Balloon policy	SAFETY - ONGOING	Wheels locked in place		
RELIGION / CULTURE PREFERENCE	None requested	RELIGION / CULTURE PREFERENCE	Side rails up X -		
LEARNING NEEDS	None identified	LEARNING NEEDS	Call light within reach of patient / caregiver -		
COMMENTS					
COMPLETED BY - PRINT					
PAIN PATIENT LABEL					



PATIENT NAME IN FULL	NAME PREFERENCE	AGE	DATE	TIME
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PEDIATRIC ADMISSION PARENT QUESTIONNAIRE

PLEASE LIST CHILD'S REGULAR DOCTOR	CHILD'S GENERAL HEALTH <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Chronic Illness
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HAS A FAMILY MEMBER BEEN SICK RECENTLY <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>Explain:</i>	FAMILY'S GENERAL HEALTH <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Chronic Illness
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CHILD'S COMMUNICABLE DISEASE HISTORY	HAS	HAD	EXPOSED TO	VACCINATED YES	VACCINATED NO	DAY CARE <input type="checkbox"/> N / A <input type="checkbox"/> No <input type="checkbox"/> Yes -	NAME / LOCATION
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Chicken Pox						<input type="checkbox"/> N / A <input type="checkbox"/> No <input type="checkbox"/> Yes -	GRADE	ATTENDANCE	EXPLAIN
Mumps						<input type="checkbox"/> N / A <input type="checkbox"/> No <input type="checkbox"/> Yes -		<input type="checkbox"/> Regular <input type="checkbox"/> Irregular -	
Measles						<input type="checkbox"/> No <input type="checkbox"/> Yes -			

PLAY / LEISURE ACTIVITIES	LIST	LIST
<input type="checkbox"/> Arts / Crafts <input type="checkbox"/> Dancing <input type="checkbox"/> Games <input type="checkbox"/> Music <input type="checkbox"/> Sports -		<input type="checkbox"/> Other -

MOBILITY - INFANT <input type="checkbox"/> Rolling <input type="checkbox"/> Crawling <input type="checkbox"/> Walking <input type="checkbox"/> Lifts Head Up	<input type="checkbox"/> Normal for Age <input type="checkbox"/> Other -
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HOME DIET <input type="checkbox"/> Baby Food <input type="checkbox"/> Formula <input type="checkbox"/> Pureed Food <input type="checkbox"/> Regular Diet <input type="checkbox"/> Toddler Diet	FORMULA <input type="checkbox"/> N / A <input type="checkbox"/> Yes -	BRAND / TYPE	AMOUNT	CONCENTRATION
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METHOD OF FEEDING <input type="checkbox"/> Bottle <input type="checkbox"/> Breast <input type="checkbox"/> Sippee Cup <input type="checkbox"/> Cup <input type="checkbox"/> Feeds Self	APPETITE <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Bad
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FOOD PREFERENCES	FOOD DISLIKES
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SLEEPS - NUMBER OF HOURS PER NIGHT	BED TIME	NAPS <input type="checkbox"/> Yes <input type="checkbox"/> No
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TOILET METHOD <input type="checkbox"/> Independent <input type="checkbox"/> Toilet Trained <input type="checkbox"/> Not Toilet Trained	DIAPERS <input type="checkbox"/> N / A <input type="checkbox"/> Disposable <input type="checkbox"/> Cloth <input type="checkbox"/> Pull-ups	CHILD'S WORDS FOR TOILETING
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CHILD'S EMOTIONS <input type="checkbox"/> Easy Going <input type="checkbox"/> Playful <input type="checkbox"/> Quiet <input type="checkbox"/> Serious <input type="checkbox"/> Stubborn <input type="checkbox"/> Talkative <input type="checkbox"/> Other -	SPECIFY
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FEARS <input type="checkbox"/> No <input type="checkbox"/> Yes -	LIST	COMFORTED BY
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CHILD LIVES WITH <input type="checkbox"/> Mother and Father <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Care <input type="checkbox"/> Other -	SPECIFY
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CONTACT INFORMATION				WILL SOMEONE BE STAYING AT THE HOSPITAL WITH THE CHILD <input type="checkbox"/> No <input type="checkbox"/> Yes - List Name and Relationship to Child
PERSON	NAME	HOME PHONE NO.	WORK TELEPHONE NO.	
Mother				
Father				
Legal Guardian				
DHS / Case Worker				

OTHER CHILDREN IN THE HOME <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>Ages:</i>	FAMILY SITUATIONS THAT THE HOSPITAL STAFF SHOULD BE AWARE OF (I.E., CULTURAL, RELIGIOUS) <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>List:</i>
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IS SOMEONE AVAILABLE TO HELP CARE FOR THE CHILD AT HOME <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>List:</i>	HAVE YOU HAD ANY MAJOR STRESS IN THE FAMILY IN THE LAST 6 MONTHS (DIVORCE, CUSTODY DISPUTE, DOMESTIC VIOLENCE, DEATH, ETC.) <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>List:</i>
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DO YOU WISH TO PARTICIPATE IN THE CARE OF THE CHILD WHILE HOSPITALIZED <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>Explain:</i>	WILL YOU NEED A GUEST TRAY FOR MEALS (\$2.50 / MEAL) <input type="checkbox"/> No <input type="checkbox"/> Yes
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DO YOU HAVE ANY CONCERNS THAT HAVE NOT BEEN ADDRESSED <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>List:</i>	
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WOULD YOU LIKE TO REQUEST A REFERRAL BY ANY OF OUR STAFF <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Dietician <input type="checkbox"/> Social Services <input type="checkbox"/> Pastoral Care <input type="checkbox"/> Lactation Specialist <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other -	SPECIFY
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COMPLETED BY	REVIEWED BY NURSE
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INITIALS	SIGNATURE	TITLE	PATIENT LABEL

