2704

PROVIDENCE Health & Services

Oregon Region

PEDIATRIC HEALTH STATUS SUMMARY

PATIENT STICKER

PRE-ADMIT

Pre-Admit Clinic: ❑ Telephone ❑ Visit Date: _____

Vital signs: _____

A. ADMIT DATA

Date: _____ **Time:** _____

Unit/Room #: _____ ❑ Bed _____ ❑ Crib _____

Admitted from: ❑ Home ❑ Other _____

Via: ❑ Walk-in ❑ Stretcher ❑ WC ❑ Carried ❑ Ambulance

Has your child had a fever, a cold, vomiting, diarrhea or other symptoms of illness within the last 48 hours? ❑ No ❑ Yes*

Has your child been exposed to a communicable disease within the last 2 - 3 weeks? ❑ No ❑ Yes*

T	P	R	BP

Ht (in cm)	Wt (in kg)	Head Circumference (in cm)	O_2sat
			% on

Broselow Color _____

When did your child last eat or drink _____

Why is your child here _____

Were treatments or tests done before arrival _____

Who is your child's primary care provider (pediatrician or other)

_____

Immunization Status:

❑ Record viewed ❑ Up to date ❑ Needs _____

❑ Record not viewed

Daily Fluid Requirement Calculation: Patients < 50 kg

100 mL x _____ (Number of kg between 1 - 10) kg = _____

+50 mL x _____ (Number of kg between 11 - 20) kg = _____

+20 mL x _____ (Number of kg over 20) = _____

Total _____ mL/24 hours

Hourly Fluid Calculation: _____ mL/24 hours ÷ 24 = _____ mL/hr

Child's primary caregiver/legal guardian: _____

Relationship: _____ ❑ Here ❑ Bands

Phone: (W) _____ (H) _____

Other caregiver: _____

Relationship: _____ ❑ Here

Phone: (W) _____ (H) _____

Child's primary language: _____

Second language: _____

Parent/Guardian preferred language for discussing health care:

_____

Interpreter needed: ❑ No ❑ Yes Language _____

❑ Contacted ❑ Here Phone _____

B. ALLERGIES

ALLERGIES: MEDICATION/FOOD ❑ No ❑ Yes **REACTION**

List: _____

_____

_____

❑ **LATEX*** ❑ Tape ❑ Iodine _____

C.

Medications ❑ None

❑ See Medication Reconciliation Form

D. DRUGS*

Is your child regularly exposed to tobacco smoke? ❑ Yes ❑ No

Is your child regularly exposed to someone who uses:

❑ Alcohol ❑ Marijuana ❑ Cocaine ❑ Methamphetamine

❑ Other _____ ❑ No

Narrative:

_____

_____

_____

_____

❑ Patient Specific Pediatric Emergency Med Sheet on Chart and bed

E. MEDICAL & SURGICAL HISTORY QUESTIONNAIRE

Yes	No	Does your child have or ever had: (CIRCLE those that apply & write in others)
		Problems with vision, hearing, sinus or ear infections, sore throats. Are there loose teeth, PE tubes, glasses or hearing aids?
		Heart problems or murmurs, circulation problems
		Sickle cell anemia, anemia, bleeding disorders
		Problem breathing, asthma, TB, coughing, pneumonia, cystic fibrosis, uses nebulizer at home
		Hepatitis or jaundice, stomach or bowel problems, recent vomiting or diarrhea
		Kidney or bladder disease or infection
		Is your child toilet trained? Bladder _____ since _____ Bowel _____ since _____
		Broken bones or muscular disorder
		Trouble moving or walking If yes, describe: _____
		Rash, eczema, hives, open sores, bruises, a skin infection that did not heal or could not be treated with antibiotics. Where: _____
		Seizures, headaches, paralysis or numb areas
		Anxiety, depression, attention deficit, learning deficit
		Diabetes
		A bad reaction to anesthetic
		Family history of high fever or muscle weakness after anesthesia
		A religious objection to blood transfusion
		Premature birth – gestation age at birth
		Is there anything else that we should know about your child? _____

List your child's surgeries, hospitalizations, and illness	Date

Responsible Person Signature

	Date/Time
RN reviewer Signature RN	
RN reviewer Signatuer RN	

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PEDIATRIC HEALTH STATUS SUMMARY, PAGE 2

KEY * = Safety * = Action Recommended

PATIENT STICKER

F. NUTRITION

Does your child have food allergies? ❑ No ❑ Yes* If yes, describe: _____

Does your child follow a special diet? ❑ No ❑ Yes*

Does your child use a feeding tube? ❑ No ❑ Yes If yes, type _____ Formula _____

Infants: ❑ Breast feeding ❑ Formula: Type _____

Type of bottle _____ Type of Nipple _____

❑ Solid foods: Types/preferences _____

Does your child have difficulty swallowing ❑ No ❑ Yes* If so describe: _____

Has your child lost any weight in the last 1 month ❑ No ❑ Yes* If so how much: _____ why: _____

Does your child have any special food likes or dislikes? ❑ No ❑ Yes If yes, _____

Does your child have any special eating utensils? ❑ No ❑ Yes If yes, ❑ Cup ❑ Plate ❑ Silverware

G. LEARNING

As caregiver:

Are there problems which may affect your learning to care for your child?

❑ No ❑ Yes: ❑ Difficulty reading ❑ Difficulty hearing ❑ Stress ❑ Non-English speaking ❑ English as a 2nd language ❑ Culture ❑ Other: _____

As caregiver:

Do you learn best by: ❑ reading ❑ listening ❑ watching ❑ doing

H. SUPPORT

Does your child need assistance with:

Bathing ❑ No ❑ Yes

Dressing ❑ No ❑ Yes

Grooming ❑ No ❑ Yes

Describe: _____

Normal Habits

Bowels: frequency _____ Last bowel movement _____ Term used _____

Bladder: frequency _____ Term used _____

Sleep: Does your child have problems sleeping?

❑ NA ❑ No ❑ Yes If yes, what helps them to sleep? _____

Does your child have a bedtime ritual?

❑ NA ❑ No ❑ Yes If yes, describe: _____

Does your child sleepwalk? ❑ NA ❑ No ❑ Yes*

Do you feel you have enough support from family, friends, church, etc? ❑ Yes ❑ No describe _____

Are you concerned about paying for food, medications, transportation, etc? ❑ No ❑ Yes* describe _____

Are there cultural/spiritual traditions or practices that may alter your child's care? ❑ Yes* describe _____

What did your child bring for comfort _____ What do they call it? _____

Has your child had a recent personal loss or experience that could interfere with their care?* _____

I. PAIN

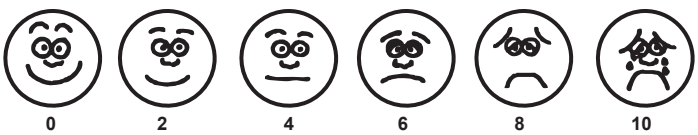
Is your child currently having pain? ❑ No ❑ Yes If yes, pain location: _____

Describe pain _____ Pain made worse by _____

What relieves the pain _____ Child's term for pain _____

Rate the pain using 0-10 scale with 0 = no pain & 10 = worse pain circle# 1 2 3 4 5 6 7 8 9 10

FACES OF PAIN SCALE: USE FOR AGE 3 OR OLDER



Explain to child that Face 0 is very happy because he doesn't hurt at all. Face 2 hurts a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to hurt this bad. Have him/her choose the face that best describes how he is feeling.

FLACC SCALE USE BIRTH - 7 YRS.

	0	1	2
Face	No particular expression	Occasional grimace or frown, withdrawn, disinterested	Frequent frown, clenched jaw, quivering chin
Legs	Normal or relaxed position	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)		Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed		Difficult to console or comfort

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J. SAFETY

Violence in the home is a significant health risk that we are concerned about, so we ask all families these questions:

Is there any reason to think you or your child will not be safe at home? ❑ No ❑ Yes*

Is there any particular family member or friend that makes your child uncomfortable? ❑ No ❑ Yes*

Are there any people who you do not want to visit your child? ❑ No ❑ Yes*

If yes, list _____

Are there any restraint orders restricting anyone from visiting your child? ❑ No ❑ Yes*

If yes, list _____

Are there firearms in your home? ❑ No ❑ Yes If yes, are they secured? ❑ No* ❑ Yes

Does your child wear a helmet when on a bicycle and/or skateboard? ❑ No* ❑ Yes

K. DEVELOPMENT

Does your child have problems with daily activities (such as school, sports, social) ❑ No ❑ Yes

Describe: _____

Does your child attend school? ❑ No ❑ Yes Where _____

Phone number _____ Grade _____

If your child is expected to be absent from school for more than 2 days, have you contacted the school to make arrangements for missed work? ❑ Yes ❑ No* If no, may we contact the school? ❑ Yes ❑ No

Does your child attend day care? ❑ Yes Where _____

DEVELOPMENT

29 Days - 4 mos:

Does your baby smile?	❑ Yes	❑ No
Does your baby babble or laugh?	❑ Yes	❑ No
Are body movements equal?	❑ Yes	❑ No
Does baby lift head when on tummy?	❑ Yes	❑ No

4 - 8 mos:

Does your baby bring hands together?	❑ Yes	❑ No
Does your baby sit with support, head steady?	❑ Yes	❑ No
Does your baby jabber?	❑ Yes	❑ No
Does your baby roll over?*	❑ Yes	❑ No

8 - 12 mos:

Does your child feed self crackers?	❑ Yes	❑ No
Does your child sit without support?	❑ Yes	❑ No
Does your child have finger thumb grasp?	❑ Yes	❑ No
Does your child have any words?	❑ Yes	❑ No
Can your child pull self to standing?*	❑ Yes	❑ No

1 - 3 yrs:

Can your child indicate wants verbally?	❑ Yes	❑ No
Does your child use short sentences?	❑ Yes	❑ No
Does your child follow directions such as "put the toy on the table"?	❑ Yes	❑ No
Does your child feed self?	❑ Yes	❑ No
Does your child walk unassisted?	❑ Yes	❑ No
Does your child climb out of bed?*	❑ Yes	❑ No

4 - 5 yrs:

Can your child identify pictures in a storybook?	❑ Yes	❑ No
Does your child play interactive games, such as hide and seek?	❑ Yes	❑ No
Can your child say both first & last name?	❑ Yes	❑ No

6 - 12 yrs:

Can your child read?	❑ Yes	❑ No
Can your child write?	❑ Yes	❑ No
Is your child in the appropriate grade in school?	❑ Yes	❑ No
Does your child participate in peer group activities?	❑ Yes	❑ No

13 - 17 yrs:

Is your child successful in school?	❑ Yes	❑ No
Does your child participate in peer group activities?	❑ Yes	❑ No
Does your child have any behaviors that worry you?*	❑ Yes	❑ No

8 - 17 yrs:

Do you smoke cigarettes?* ❑ Yes ❑ No

Do you use:*

❑ Alcohol ❑ Marijuana ❑ Cocaine ❑ Methamphetamine

Other _____ ❑ No

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L. DISCHARGE

Will you be able to manage the care of your child at home after discharge? ❑ **Yes** ❑ **No***

If no, describe: _____

Returning to home with parent(s)? ❑ Yes ❑ No Other _____

If needed have you arranged for help at home? ❑ Yes ❑ No Describe _____

_____

Are you currently using any of the following services?*

❑ WIC ❑ Community Health Nursing: County _____

❑ Home Nursing Services: Agency _____

❑ Medical Equipment: Provider _____

Do you have a ride home? ❑ Yes ❑ No ❑ Here ❑ Will return ❑ Call when ready _____

INFO SOURCE

Name & relationship to patient: _____

INITIALS	SIGNATURE/TITLE	DATE/TIME	INITIALS	SIGNATURE/TITLE	DATE/TIME
	Interviewer			RN Reviewer	

Narrative & additions (Include statements on how parents wish to be involved in child's care and any concerns that parent/legal guardian wish to discuss:	section

If questions about completing this form, please call:

PSVMC 503-216-1993
PPMC 503-215-1874
PMH 503-513-8843
PNMC 503-537-1450
PHRMH 541-386-3911
PMMC 541-732-5537
PSH 503-717-7239
PWFMC