UNIVERSITY
MEDICAL CENTER

PEDIATRIC ADMISSION PROFILE

Date: ______________________________

<table>
<thead>
<tr>
<th>Valuables</th>
<th>N/A Sent Home</th>
<th>Placed in Safe</th>
<th>Remains at Bedside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglasses</td>
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<tr>
<td>Hearing Aid</td>
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<tr>
<td>Clothing</td>
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<td>Other:</td>
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<tr>
<td>Other:</td>
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Valuables: I fully understand that HUMC is not responsible for any personal property brought in or retained at the bedside at anytime. I fully understand that HUMC provides a safe for my valuables should I wish to place them there for the duration of my hospital stay.

Signature of Patient/Significant Other: ____________________________
Witness: ____________________________

Section I

Source of Information: ____________________________ Relationship: ____________________________

Reason for Admission/Chief Complaint:

ALLERGIES: ☐ Denies ☐ Latex ☐ Contrast Dye ☐ Food: ____________________________

☐ Medications: ____________________________

☐ Other: ____________________________

Explain Reaction: ____________________________

Medications

<table>
<thead>
<tr>
<th>Name or Purpose</th>
<th>Dose/Route/Frequency</th>
<th>Last Dose</th>
<th>Left at Home</th>
<th>Sent Home</th>
<th>To Pharmacy</th>
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</tbody>
</table>

Able to swallow pills? ☐ Yes ☐ No
If no, how: ____________________________

Oxygen: ☐ No ☐ Yes* Method: ____________________________

Respiratory Treatments: ☐ No ☐ Yes* Type: ____________________________

Section I Completed by: ____________________________

(signature) ____________________________

Date/Time: ____________________________

* PLACE REFERRAL TO APPROPRIATE DISCIPLINE
SECTION II - HEALTH HISTORY

Source of Information Section II-XII:

Relationship:

Actual Weight: ______ kg  Actual Height/Length: ______ cm

H.C. ______ cm

(If clinically indicated)

Advance Directive:

☐ Less than 18 years old, N/A
☐ No  ☐ Yes, Copy on Chart  ☐ Yes, Copy Requested from: ☐ Patient/Family
☐ Information Requested  ☐ Information Given

MD  ☐ Medical Records

If clinically indicated)

or if < 2 years old

Transferred From/Admitted From:

☐ Home  ☐ Homeless*  ☐ Other/Facility Name:

Emergency Contact This Admission:

Name

Relationship

Work #:

Home #:

Recent Infections or Exposures:

☐ Denies  ☐ Chicken Pox  ☐ Herpes Zoster/Shingles  ☐ T.B.

☐ Other:

Primary Language:

☐ Understands English  ☐ Reads English

☐ Speaks English  ☐ Interpreter Required

Immunizations Up-To-Date:

☐ Yes  ☐ No, needs:

Outpatient Services:

☐ Not Applicable  ☐ Dialysis  ☐ Radiation Oncology  ☐ Retuen Clinic  ☐ Other

Vascular Access:

☐ Not Applicable

Type: __________________________ Who changes dressing:

Last dressing change:

Blood / Blood Component Transfusion History:

☐ Not Applicable

History of blood transfusion reaction:

Premeedication ____________________________

History of platelet transfusion reaction:

Premeedication ____________________________

Any known disabilities or health problems

Previous hospitalization: When __________________________ Where __________________________

Why:

Anesthesia history:

☐ Uneventful  ☐ Other:

Birth weight (infants):

Reproduction:

☐ N/A  ☐ LMP ________ Could you be pregnant? ________

SECTION III - PSYCHOSOCIAL HISTORY

Tobacco:

☐ Yes  ☐ No  How Long?: ______ Type: ______

Amount: __________ Quit: (when) __________

Has patient or someone in your house smoked in the last year?  ☐ Yes  ☐ No

If yes, would you like:

☐ Information on smoking cessation (carenotes)  ☐ Referral to a smoking cessation program/counseling

☐ Patient/Family refused

Alcohol:

☐ Yes  ☐ No  Type: ______ Amount: ______ Last Drink: ______

Illicit Drug Use:

☐ Yes  ☐ No  Type: ______ Amount: ______ Last Use: ______

Cultural needs/considerations affecting hospitalization/plan of care:

☐ Denies

Spiritual resources requested:

☐ Denies

Special needs we should be aware of:

☐ Denies

Is child attending school:

☐ Yes*  ☐ No

* PLACE REFERRAL TO APPROPRIATE DISCIPLINE

PEDIATRIC ADMISSION PROFILE

MEDICAL RECORD

PAGE 2

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**SECTION V - GROWTH AND DEVELOPMENT**

Prior to admission able to complete ADL:  ☐ Yes  ☐ No, related to age  ☐ No, explain ____________________________

Developmental Level: ________________________________________________________________

Developmental Needs: _________________________________________________________________

**SECTION VI - ACTIVITY/SAFETY**

Activity: A check in any of the following boxes requires a referral for a Screen/Evaluation by Physical Therapy*:

☐ Deviation from age appropriate milestones related to activity  ☐ Unsteady gait/balance for age

Use of assistive devices  ☐ Use of braces/prosthetics

Safety:  ☐ Disease specific isolation for: ________________________________________________

☐ Protective isolation for: _____________________________________________________________

☐ Seizure precautions: _______________________________________________________________

**MORSE FALL SCALE**

<table>
<thead>
<tr>
<th>History of Falls</th>
<th>☐ Yes</th>
<th>☐ No</th>
<th>25</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Diagnosis</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Ambulatory Aid</td>
<td>☐ Furniture</td>
<td>☐ Crutch/Cane/Walker</td>
<td>☐ None/Bedrest/Wheelchair/Nurse</td>
<td>30</td>
</tr>
<tr>
<td>IV/Saline Lock</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td>20</td>
<td>0</td>
</tr>
</tbody>
</table>

| Gait Transferring | ☐ Impaired | ☐ Weak | ☐ Normal/Bedrest/Immobile | 20 | 10 | 0 |
| Mental Status | ☐ Forgets Limitations | ☐ Oriented to Own Ability | 15 | 0 |

| TOTAL | Low Risk 0-24 | Moderate Risk 25-50 | High Risk ≥ 51 |

If High Risk, place referral to PT for an evaluation/screen. Use ICD for developmental or neurological issues, use Physical Medicine and Rehab for all others.

**SECTION VII - NUTRITION**

Feed Self:  ☐ Yes  ☐ No  Diet prior to admission:  ☐ Table Food  ☐ Juvenile Food  ☐ Strained  ☐ Bottle  ☐ Breast  ☐ Formula: ____________________________  ☐ Taken Warm  ☐ Room Temp  ☐ Special Diet: ____________________________

Volume/Frequency: _________________________________________________________________

**HIGH RISK SCREEN**

Does your child follow a medically prescribed diet?  ☐ Yes  ☐ No

History of multiple (4 or more) food allergies or intolerances? If yes, specify ____________________________  ☐ Yes  ☐ No

Does your child require tube feeding/TPN/Nutrition Supplements? If yes, specify ____________________________  ☐ Yes  ☐ No

Any unintentional weight change in last month? If yes, _______________ amount in ___________ weeks/months  ☐ Yes  ☐ No

Use of infant formula > 20 cal/oz  ☐ Yes  ☐ No

Difficulty sucking or weak suck  ☐ Yes  ☐ No

Diagnosis of New Onset Diabetes  ☐ Yes  ☐ No

Any yes answer in this section requires a Nutrition Consult*
SECTION VIII - ELIMINATION

Toilet Trained: ☐ Yes ☐ No  History of Diarrhea: ☐ Yes ☐ No
History of Constipation: ☐ Yes ☐ No
Urinary Problems: ________________________________

SECTION IX - COGNITIVE / SENSORY PERCEPTION

Vision: ☐ No difficulty reported ☐ Glasses ☐ Contacts ☐ Other: ____________
Hearing: ☐ No difficulty reported ☐ R ☐ L ☐ Hearing Aid ☐ Other: ____________
Speech: ☐ Appropriate for age ☐ Other: ________________________________

SECTION X - PAIN HISTORY ASSESSMENT

Do you have pain now? ☐ Yes ☐ No ☐ Unable to verbalize
How does your child express pain? ________________________________
Pain Scale: ☐ NIPS ☐ FLACC ☐ Faces ☐ 0-10
☐ Other: _______________________________________________________
Pain intensity/Score: _______ Describe: ____________________________

If pain intensity/score ≥ 3 on the NIPS or ≥ 4 on other scales, continue with pain assessment on Nurse's Assessment Record.

SECTION XI - TEACHING

Readiness to Learn: ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Preferred Learning Style</th>
<th>Potential Barriers to Learning</th>
<th>Learning Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Visual</td>
<td>☐ None</td>
<td>☐ Diagnosis</td>
</tr>
<tr>
<td>☐ Written</td>
<td>☐ Desire/Motivation</td>
<td>☐ Safe Use of Equipment</td>
</tr>
<tr>
<td>☐ Demonstration</td>
<td>☐ Physical Limitations</td>
<td>☐ Medications</td>
</tr>
<tr>
<td>☐ Learning Deficiency:</td>
<td>☐ Limited Learning Ability</td>
<td>☐ Community Resources</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Religious</td>
<td>☐ Nutrition/Diet</td>
</tr>
</tbody>
</table>

SECTION XII - INITIAL DISCHARGE ASSESSMENT:

Refer to Case Management if home environment is inconsistent with patients needs, or patient required services prior to admission (ie. O2, parental/enteral feeding) or there is concern with home environment supporting safe patient care.

Previous Home Care Services? ☐ Yes ☐ No Who does child live with? ________________________________
Who will care for the child at home? ________________________________

Based on obtained patient information and nursing assessment - referral related to discharge needs made to:
☐ Case Management ☐ Social Services ☐ Other: ________________________________ ☐ None Required

Section II Completed by: ________________________________ (signature) (title) Date/Time: ________________________________

* PLACE REFERRAL TO APPROPRIATE DISCIPLINE

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