PEDIATRIC
ADMISSION ASSESSMENT

Date_____ Time_____ Addressograph

Person to Notify in Case of Emergency:
Name_____
Phone _____
Relationship _____

Admitted from:
Home ( ) ER ( )
Swingbed ( ) Surgery ( )
Nursing Home ( ) MD Office ( )

Orientation to Nursing Unit:
Nurse Call System ( )
Crib / Side Rails ( )
Bathroom ( )
Phone ( )
No Smoking ( )
No leaving children unattended ( )
Bed Controls ( )
ID Bracelet ( )
TV Controls ( )
Visiting Hours ( )
Patient Information ( )

Admitted via:
Stretcher ( ) Ambulatory ( )
Wheelchair ( ) Parent's Arms ( )

Cribs must have side rails up @ all times when occupied ( )
No toys or objects to create sparks or friction if in croup tent ( )
Bed / Crib must be kept in lowest position @ all times ( )

Immunizations Current? ( ) Yes ( ) No

Chief Complaint: _____
_____

Vital Signs: Temp_____ Pulse _____ Has received tx for this condition prior to admission: ( ) Yes ( ) No
Resp _____ B/P_____ If yes, explain: _____

Disposition of Valuables

Caldwell County Hospital will not assume responsibility for lost or damaged valuables, clothing, or personal items kept in the patient's possession. Valuables should be taken home or secured by the hospital.

( ) Valuables taken home ( ) Valuables secured by hospital* ( ) No valuables with patient
*See valuables envelope for description. Envelope # _____
Patient / Family Signature _____
Witness Signature _____
Date_____ Time _____

Valuables picked up by _____

Witness _____Date / Time _____

Health Profile: Informant: ( ) Patient ( ) Other _____

Disposition of Medication: ( ) Left at Home ( ) Stored at Nurses Station ( ) At Bedside
Sent home with _____

Have you been hospitalized at our facility in the past 7 days? ( ) Yes* ( ) No
***If yes, has there been any changes in your status since last admission? ( ) Yes* ( ) No**
***If yes, COMPLETE ASSESSMENT; if no, copy previous assessment and attach to this assessment.**

Rev. 1/05

Medical History and Previous Surgery: ( ) Heart ( ) Diabetes ( ) Seizures ( ) HTN ( ) GI
( ) Thyroid ( ) Neuro ( ) EENT ( ) Musculoskeletal ( ) Cancer ( ) GU ( ) Pulmonary
( ) Childhood Diseases / Illnesses ( ) Recent exposure to other Communicable Diseases: Date of exposure: _____
Explain _____

_____

Ever had a blood transfusion? ( ) Yes* ( ) No *If yes, when: _____

Social / Environmental Assessment:

1. Patient lives: ( ) Alone ( ) With family ( ) At home ( ) Nsg home ( ) With S/O
   ( ) Siblings _____
2. Habits: ( ) Tobacco _____
   ( ) Member of household uses tobacco
   ( ) Alcohol _____
   ( ) Member of household uses alcohol
   ( ) Recreational Drugs _____
   ( ) Member of household uses recreational drugs
3. Education: Last grade in school attended: (please circle)
   1 2 3 4 5 6 7 8 9 10 11 12
   Can read? ( ) Yes ( ) No
   Can write? ( ) Yes ( ) No
4. Is Home Health involved in your Care? ( ) Yes ( ) No
5. Assistance Required for Care:
   Toileting: ( ) Potty Trained ( ) Needs Assist ( ) Independent
   ( ) Wears Diapers ( ) Wears Diapers at night only
   ( ) Goes to Bathroom Alone ( ) Is a Bedwetter
   Medication: Taken best as: ( ) Liquid ( ) Chewable Tabs ( ) Crushed and mixed with _____
   ( ) Swallow Pills
   Emotional Support: Child relys on: ( ) Mother ( ) Father ( ) Sibling ( ) Other _____
   Who else besides parents might be staying with child? _____
   Has your family had any recent changes in your life? (moved, divorce, birth, death, new job, etc.):
   ( ) Yes ( ) No If yes, explain: _____
6. Abuse / Neglect / Exploitation Screen

Yes	No	Questions
( )	( )	Do you feel safe in your home?
( )	( )	Are you afraid of anyone?
( )	( )	Have you ever been physically, sexually or emotionally abused?
( )	( )	Within the past year, have you ever been hit, slapped, kicked, or otherwise physically hurt?
( )	( )	Have you ever been touched in a manner that makes you feel uncomfortable?

Yes	No	Observations
( )	( )	Evidence of neglect by self?
( )	( )	Evidence of neglect by caretakers?
( )	( )	Evidence of abuse by self or others?

If yes is checked on any of the above items, consult Police, Social Services and notify the MD.

Social Services Contact: _____ Time: _____

Police Contact: _____ Time: _____

Physical Assessment (Must be completed by an RN)

Skin

Color Impairment: ( ) None ( ) Pallor
( ) Flushed ( ) Cyanosis ( ) Jaundice
( ) Other _____

Temperature: ( ) Warm ( ) Hot ( ) Cool

Turgor: ( ) Good ( ) Fair ( ) Poor

Impairment of Skin: ( ) Yes* ( ) No

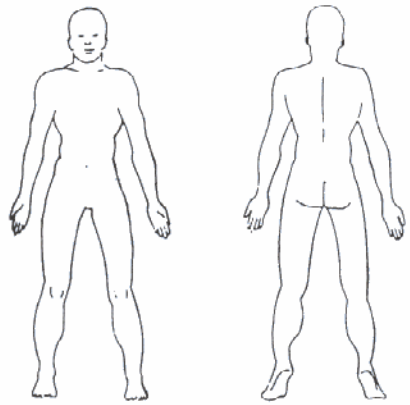
*If yes, describe / mark location on diagrams:

_____

_____

_____

SKIN ASSESSMENT:



Oral / Dental / Nasal

Teeth Condition: ( ) Good ( ) Fair ( ) Poor ( ) N/A

Dentures: ( ) Upper ( ) Lower ( ) Partial ( ) Complete
( ) With Patient ( ) Not with Patient

Gums: ( ) Pink ( ) Pale ( ) Inflamed ( ) Bleeding
( ) Moist ( ) Dry

Nose: ( ) Nosebleeds ( ) Drainage ( ) No problems
Describe _____

Hygiene

Bathing: ( ) Minimal Assist ( ) Partial Assist ( ) Complete

Condition on arrival: _____

Oral Hygiene: ( ) Self ( ) Assist ( ) Complete

Hair Condition: _____

Neuro Status

( ) Conscious ( ) Semiconscious ( ) Unconscious

( ) Alert ( ) Oriented to: ( ) Person ( ) Place ( ) Time

Weakness / Paralysis: ( ) None ( ) Left Arm ( ) Right Arm ( ) Left Leg ( ) Right Leg

Range of Motion: ( ) Independent ( ) Requires Assistance

Pupils / Eyes

Pupils: ( ) Equal ( ) Unequal: R < L or L < R ( ) Reactive ( ) Nonreactive: R L

Eyes: ( ) Drainage: R L Describe: _____

Vision

( ) Adequate ( ) Decreased: R L ( ) Blind: R L ( ) Cataracts: R L ( ) Prosthesis: R L

( ) Glasses / Contacts: ( ) With Patient ( ) Not with Patient

Speech / Swallowing

Speech: ( ) Clear ( ) Easily Understood ( ) Slurred ( ) Partially Understandable
( ) Cannot be Understood ( ) See Developmental Screen

Swallows: ( ) Without Difficulty ( ) With Difficulty ( ) Chokes on Saliva ( ) Chokes on Liquids
( ) Chokes on Solids

Hearing / Ears

Hearing: ( ) Adequate ( ) Decreased: R L ( ) Hearing Aid: R L ( ) With Patient

( ) Deaf: R L ( ) Uses Sign Language ( ) Reads Lips ( ) Communicates through Writing

Ears: Drainage: R L Describe: _____

Mobility

( ) Independent ( ) Needs Minimal Assist ( ) Needs Significant Assist ( ) Requires Total Assist

( ) Uses Crutches ( ) Uses Walker ( ) Uses Wheelchair ( ) Uses Cane
( ) With Patient ( ) Not with Patient

( ) Uses Limb Prosthesis ( ) With Patient ( ) Not with Patient

( ) See Developmental Screen

Respiratory / Cardiovascular

Respiratory Problems: ( ) None ( ) Wheezing ( ) Stridor ( ) Dyspnea ( ) Hemoptysis
( ) Cough ( ) Nonproductive ( ) Productive Describe: _____
Duration: _____
( ) Dyspnea ( ) Exertional ( ) At Rest
( ) Irregular Breathing Pattern: _____
Breath Sounds: _____

Aids to Respiration: ( ) None ( ) Oxygen at Home: Amt. / Del. Method _____
Neb txs at Home ( ) Suctioning ( ) Tracheostomy ( ) Other _____

Cardiovascular Problems: ( ) None ( ) Chest Pain - Frequency / Duration / Precipitating & Alleviating Factors:
_____
( ) Cyanosis ( ) JVD ( ) Irregular Pulse / Rhythm Other _____

Cardiovascular Aids: ( ) Pacemaker: ( ) Demand ( ) Fixed Rate
( ) Implanted Defibrillator ( ) Other _____

Elimination

Bowel Status:

Bowel Sounds:	LUQ	RUQ	LLQ	RLQ
Present				
Absent				
Hyperactive				
Hypoactive				

Frequency of BM: ( ) Daily ( ) BID ( ) QOD Other: _____
( ) Formed Stool ( ) Constipation ( ) Diarrhea: Color: _____
Date of last BM: _____
Bowel Problems: ( ) None ( ) Pain ( ) Flatulence ( ) Change in Bowel Habits
( ) Bloody Stools ( ) Rectal Drainage ( ) Incontinence ( ) Hemorrhoids ( ) Other _____
Abdomen: ( ) Soft ( ) Firm ( ) Tender ( ) Non-Tender ( ) Distended ( ) Non-Distended

Urinary Status:

Problems: ( ) None ( ) Cloudy Urine ( ) Foul Smell ( ) Dysuria ( ) Hematuria ( ) Nocturia
( ) Incontinence ( ) Stress ( ) Constant ( ) Urgency / Frequency ( ) Retention ( ) Burning
( ) Pain Other: _____
( ) Ostomy ( ) Self Cath: Frequency _____
( ) Indwelling Foley - date last changed: _____ ( ) Palpable Bladder

GU

Female

Currently Pregnant: ( ) Yes ( ) No
( ) Menses Problems: _____
_____
Date of last Menstrual Period: _____
_____
( ) Vaginal Discharge: _____
_____
( ) Hx STDs: _____

Male

( ) Penile Discharge _____
( ) Hx STDs: _____
( ) Undescended Testes
( ) Hypo / Hyperspadius

Other: Male / Female: _____
_____
_____

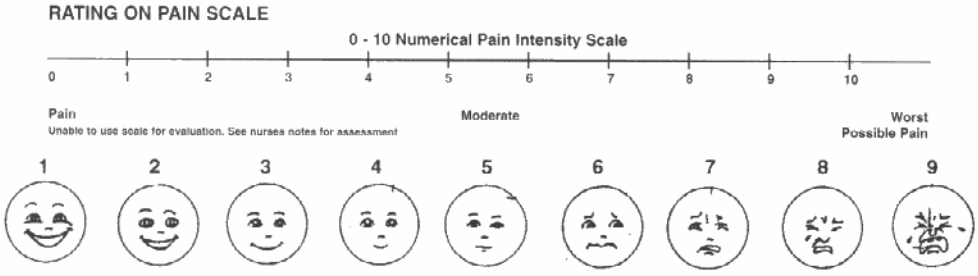
Comfort / Rest / Sleep

Sleep

( ) No Problems ( ) Awakens Frequently ( ) Unable to Fall Asleep Easily
( ) Requires Sleeping Medication - Med / Dose / Frequency _____
Avg. # Hrs. Slept Each Night _____ # Pillows used _____
( ) Sleeps with Night Light On

Comfort / Pain

Is the patient currently having pain or admitted with a pain related diagnosis? ( ) Yes ( ) No
If yes, complete this section.
Intensity (circle appropriate pain intensity level)



Location: _____
Duration: _____ ( ) Continuous ( ) Intermittent
( ) Chronic - > 6 months ( ) Acute - < 6 months
Type: ( ) Ache ( ) Sharp ( ) Dull ( ) Shooting ( ) Stabbing ( ) Burning ( ) Pressure
( ) Cramping ( ) Other: _____
Relieved by: ( ) Rest ( ) Heat ( ) Cold ( ) Position ( ) Activity
( ) Meds: _____ ( ) Other: _____
Aggravated by: _____
Do you have any personal, cultural, spiritual and/or ethnic beliefs that may affect the way your pain is treated?
( ) Yes ( ) No If yes, explain: _____
_____

Psychological Status

Body Image / Self Concept Problems: ( ) None Identified at this time ( ) Signs / Symptoms of Depression ( ) Suicidal Ideations: _____

Spiritual Needs: ( ) Yes ( ) No Requests Minister, etc. be notified: ( ) Yes ( ) No

Minister's Name / Phone No._____

Observation of Patient Behavior / Interaction: ( ) Cooperative ( ) Anxious ( ) Withdrawn ( ) Restless ( ) Calm ( ) Uncooperative ( ) Unresponsive

Developmental / Other Needs Assessment

Infant	Toddler	Preschooler	School Age Child	Adolescent
0 - 12 Months	1 - 3 Years	4 - 5 Years	6 - 12 Years	13 - 17 Years
Social _____Smiles spontaneously _____Plays peek-a-boo _____Plays pat-a-cake _____Plays ball **Fine Motor** _____Grasps rattle _____Reaches for object _____Demonstrates pincer grasp **Language** _____Squeals / laughs _____Imitates speech / sounds _____Says "dada or mama" **Gross Motor** _____Lifts head from lying position _____Lifts chest to 90 degrees _____Sits without support _____Pulls self to standing _____Stands well alone / cruises **Other** Breast Feeding: ( ) Yes ( ) No # of Feedings / 24 hrs.:_____ Formula: ( ) Yes ( ) No Formula Name: _____ Table Food: _____	**Social** _____Plays tag _____Puts on clothing _____Washes & dries hands **Fine Motor** _____Copies "O" and vertical line onto page _____Builds tower of 8 cubes **Language** _____Uses plurals _____Gives first and last names **Gross Motor** _____Pedals tricycle _____Balances on one foot **Other** Breast Feeding: ( ) Yes ( ) No Formula: ( ) Yes ( ) No Formula Name:_____ _____ Table Food ( ) Baby Food ( ) Word used for toileting: _____ Security Object: _____	**Social** _____Separates from mother easily _____Buttons up _____Dresses without supervision **Fine Motor** _____Picks longer line _____Copies "+" _____Draws man with 3 parts **Language** _____Recognizes 3 or more colors _____Gives opposite analogies (hot/cold, up/down, etc.) _____Comprehends prepositions (on, over, under, beside) **Gross Motor** _____Can jump from stationary position _____Hops on one foot _____Performs toe to heel walk **Other** Word used for toileting: _____ Security Object: _____	**Social** _____Engages in group activities with same sex peers (scouts, sports, friends) **Cognitive** _____Wide range of vocabulary _____Learns to read _____Learning math skills (adds, subtracts, multiplies, divides) _____Begins collections (hobbies) **Physical** _____Exhibits physical endurance (plays sports, games) _____Increased fine motor ability (writing, painting, drawing)	**Social** _____Interacts with peers of same & opposite sex **Cognitive** _____Masters skills of language, writing, reading & math **Physical** _____Developed sex characteristics **Date Menstruation Began:** _____

Discharge Needs

( ) Housing ( ) Physical Care ( ) Housekeeping ( ) Meals ( ) Finances ( ) Transportation ( ) Home Health ( ) Nursing Home Placement ( ) School Needs Met ( ) None Identified at this time ( ) Discharge Planner Notified

Plan of Care Reviewed with:

( ) Patient ( ) Family ( ) Significant Other

Other Notes: _____

_____

_____

_____ _____

Signature / Title of Nurse Collecting Data Date / Time

_____ _____

Signature / Title of Nurse Performing Assessment Date / Time

Is this child's condition affected by the family? ( ) No ( ) Yes*

*If Yes, explain: _____

Action Taken: _____

(i.e., child's diagnosis is asthma; smokers in household, etc.)

Is the family affected by this child's hospitalization? ( ) No ( ) Yes*

*If Yes, explain: _____

Action Taken: _____

(i.e., missed work by parents = financial hardship, etc.)

FALL RISK ASSESSMENT

	SCORE	
Confused, disoriented, hallucinating, combative	20	
Unstable gait, weakness	20	
Hx of syncope, seizures, postural hypotension	20	
Recent hx of falls	20	
Use of restraints	20	
Paralysis, hemiplegia, stroke, TIA	15	
Post-op condition, sedated	10	
Impaired vision	10	
Drug or alcohol withdrawal	10	
Use of walker, cane (other assistive aids)	10	
Narcotics, diuretics, antihypertensives, hypnotics, tranquils, poly-pharmacy (more than 5 scheduled meds)	10	
Bowel, bladder urgency, incontinent	10	
Equipment with risk for entanglement (IV's, O2, feeding tubes, etc.)	10	
Age 70 or above	10	
Age 12 or below	5	
Language barrier	5	
Poor hearing	5	
SCORE		
High Risk Interventions Implemented (Initial)		

A score of **35** or above may indicate the patient is at high risk for falling. These patients at high risk for fall shall have the following interventions implemented. Nursing shall monitor these at least every 2 hours.

- Visually observe patient every 2 hours. If awake, offer comfort measures and toileting.
- Instruct patient and/or family to ask for assistance for any patient activities.
- All items for patient's use will be within easy reach.
- Reassess for safe footwear.
- Reinforce use of assistive devices, if used.
- Reassess for a clutter free, well-lit environment.
- Re-orient and repetitively reinforce use of call bell. Ensure it is within reach.
- Consider a room closer to the nursing station.
- Utilize the Bed Check Alarm System / chair alarms.
- Utilize high-risk identification including green dots on wristband, door chart and near room number on the nurse call system.

Date:_____ Height:_____ Weight:_____

Allergies (Medications, OTCs, Food, Environmental) & Type of Reaction:

	Pregnant? ( ) Yes ( ) No
	EDC_____
	Lactating? ( ) Yes ( ) No

Current Medications / Herbs / Vitamins / OTC Meds	Dose	Frequency	Last Dose

Addressograph - Send Copy to Pharmacy

Date:_____

Physical Therapy Screen

- ☐ Asymmetrical movements of lower extremities and head
- ☐ No rolling over in children past 5 months of age
- ☐ No sitting up in children past 7 months of age
- ☐ Not walking in children past 15 - 18 months of age

Addressograph - Send Copy to P.T.

Date:_____

Nutritional Screen

Special diet at home:_____

Dietary likes / dislikes:_____

- ☐ Weight loss of 5 - 10 lbs. in past 3 months; ☐ NOP > 24 hours
- ☐ Hasn't eaten for > 2 days; ☐ Loss of appetite; ☐ Altered taste sensation
- ☐ Special dietary restrictions; ☐ Persistent diarrhea; ☐ Difficulty swallowing
- ☐ *Hx of Anorexia; ☐ *Hx of Bulimia; ☐ *Frequent use of laxatives
- ☐ Obesity for age

* = Notify MD if checked

Cultural, Ethnic, Religious Food Preferences _____

Addressograph - Send copy to Dietary

Date:_____

Speech Screen

- ☐ Protrusion of tongue while swallowing in child past 3 years of age
- ☐ Doesn't localize to sound in child past 5 months of age
- ☐ Less than 50 word vocabulary at 3 - 4 years of age
- ☐ Immature speech by age 5 years
- ☐ Not combining words to form short sentences by age 3 - 4 years
- ☐ Any generalized feeding problems

Addressograph - Send copy to Speech

_____ _____

Nurse's Signature Date / Time