PEDiatric
admission Assessment

Date________________________ Time________________________

Person to Notify in Case of Emergency:
Name________________________________________
Phone________________________ Relationship________________________

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

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

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 ( )

Crios 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

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 relies 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 Yes No Observations
   ( ) ( ) Do you feel safe in your home? ( ) ( ) Evidence of neglect by self?
   ( ) ( ) Are you afraid of anyone? ( ) ( ) Evidence of neglect by caretakers?
   ( ) ( ) Have you ever been physically, sexually or emotionally abused? ( ) ( ) Evidence of abuse by self or others?
   ( ) ( ) 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? _______________________

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:

[Diagram of 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: ________________________________

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:

<table>
<thead>
<tr>
<th>Bowel Sounds:</th>
<th>LUQ</th>
<th>RUO</th>
<th>LLO</th>
<th>RLO</th>
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<tbody>
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<td>Present</td>
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<td>Absent</td>
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<td>Hyperactive</td>
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<td>Hypoactive</td>
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Rev. 1/05
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 ( )

( ) 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)

RATING ON PAIN SCALE

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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</table>

Pain: Unable to use scale for evaluation. See nurses notes for assessment

Moderate

Worst Possible Pain

0 - 10 Numerical Pain Intensity Scale

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

<table>
<thead>
<tr>
<th>Infant</th>
<th>Toddler</th>
<th>Preschooler</th>
<th>School Age Child</th>
<th>Adolescent</th>
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</thead>
<tbody>
<tr>
<td>0 - 12 Months</td>
<td>1 - 3 Years</td>
<td>4 - 5 Years</td>
<td>6 - 12 Years</td>
<td>13 - 17 Years</td>
</tr>
<tr>
<td>Social</td>
<td>Social</td>
<td>Social</td>
<td>Social</td>
<td>Social</td>
</tr>
<tr>
<td>Smiles spontaneously</td>
<td>Plays tag</td>
<td>Separates from mother easily</td>
<td>Engages in group activities with same sex peers (scouts, sports, friends)</td>
<td></td>
</tr>
<tr>
<td>Plays peek-a-boo</td>
<td>Puts on clothing</td>
<td>Buttons up</td>
<td>Interacts with peers of same &amp; opposite sex</td>
<td></td>
</tr>
<tr>
<td>Plays pat-a-cake</td>
<td>Washes &amp; dries hands</td>
<td>Dresses without supervision</td>
<td></td>
<td></td>
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<tr>
<td>Plays ball</td>
<td>Fin Motor</td>
<td>Fine Motor</td>
<td></td>
<td></td>
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<tr>
<td>Grasps rattle</td>
<td>Copies “O” and vertical line onto page</td>
<td>Picks longer line</td>
<td>Masters skills of language, writing, reading &amp; math</td>
<td></td>
</tr>
<tr>
<td>Reaches for object</td>
<td>Builds tower of 8 cubes</td>
<td>Copies “4”</td>
<td></td>
<td></td>
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<tr>
<td>Demonstrates pincer grasp</td>
<td>Language</td>
<td>Language</td>
<td>Cognitive</td>
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<td></td>
<td>Uses plurals</td>
<td>Recognizes 3</td>
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<td></td>
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<td></td>
<td>Gives first and last names</td>
<td>or more colors</td>
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<td></td>
<td>Gross Motor</td>
<td>Pedestal tricycle</td>
<td>Gives opposite analogies (hot/cold, up/down, etc.)</td>
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<tr>
<td></td>
<td>Balances on one foot</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td>Breast Feeding: ( ) Yes ( ) No</td>
<td>Breast Feeding: ( ) Yes ( ) No</td>
<td>Comprehends prepositions (on, over, under, beside)</td>
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<td>Formula: ( ) Yes ( ) No</td>
<td>Formula: ( ) Yes ( ) No</td>
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<td>Formula Name:</td>
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<td>Table Food ( )</td>
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<td>Baby Food ( )</td>
<td>Baby Food ( )</td>
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<td>Word used for toileting:</td>
<td>Word used for toileting:</td>
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<td>Security Object:</td>
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<tr>
<td>Discharge Needs</td>
<td>Housing ( ) Physical Care ( ) Housekeeping ( ) Meals ( ) Finances ( ) Transportation</td>
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<td></td>
<td>( ) Home Health ( ) Nursing Home Placement ( ) School Needs Met ( ) None Identified at this time</td>
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<td></td>
<td>( ) Discharge Planner Notified</td>
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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.)

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**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, tranquilizers, 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: 

<table>
<thead>
<tr>
<th>Pregnant?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>EDC</td>
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<tr>
<td>Lactating?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<th>Current Medications / Herbs / Vitamins / OTC Meds</th>
<th>Dose</th>
<th>Frequency</th>
<th>Last Dose</th>
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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

Date: 

Nutritional Screen

Special diet at home: 

Dietary likes / dislikes:

☐ Weight loss of 5 - 10 lbs. in past 3 months; ☐ NPO > 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

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

Nurse's Signature

Date / Time