UNIVERSITY
MEDICAL CENTER

# PEDIATRIC ADMISSION PROFILE

Patient Name _____ MR# _____

Date: _____

| Valuables | N/A | Sent Home | Placed in Safe | Remains at Bedside |
|---|---|---|---|---|
| Eyeglasses | | | | |
| Hearing Aid | | | | |
| Clothing | | | | |
| Other: | | | | |
| Other: | | | | |

***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

| Name or Purpose | Dose/Route/Frequency | Last Dose | Left at Home | Sent Home | To Pharmacy |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |

**Able to swallow pills?** ❒ Yes ❒ No If no, how: _____

**Oxygen:** ❒ No ❒ Yes* Method: _____

**Respiratory Treatments:** ❒ No ❒ Yes* Type: _____

**Section I Completed by:**

_____

*(signature)* *(title)*

**Date/Time:** _____

***PLACE REFERRAL TO APPROPRIATE DISCIPLINE***

Patient Name _____ MR# _____

## SECTION II - HEALTH HISTORY

**Source of Information Section II-XII:** _____

Relationship: _____

**Actual Weight:** _____ kg **Actual Height/Length** _____ cm (if clinically indicated) **H.C.** _____ cm (if clinically indicated or if < 2 years old)

***Advance Directive:*** ❒ Less than 18 years old, N/A

❒ No ❒ Yes, Copy on Chart ❒ Yes, Copy Requested from: ❒ Patient/Family ❒ MD ❒ Medical Records

❒ Information Requested ❒ Information Given

**Transferred From/Admitted From:** ❒ Home ❒ Homeless* ❒ Other/Facility Name: _____

*Work #:* _____

**Emergency Contact This Admission:** _____ *Home #:* _____

*Name* *Relationship*

**Recent Infections or Exposures:** *(within the last month)* ❒ Denies ❒ Chicken Pox ❒ Herpes Zoster/Shingles ❒ T.B.

❒ Other: _____

**Primary Language:** _____ ❒ Understands English ❒ Reads English

(if other than English) ❒ Speaks English ❒ Interpreter Required

**Immunizations Up-To-Date:** ❒ Yes ❒ No, needs: _____

**Outpatient Services:** ❒ Not Applicable ❒ Dialysis ❒ Radiation Oncology ❒ Reuten 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: _____ Premedication _____

History of platelet transfusion reaction: _____ Premedication _____

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***

## 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

| | | | | | |
|---|---|---|---|---|---|
| History of Falls | ❒ Yes<br>❒ No | 25<br>0 | Gait Transferring | ❒ Impaired<br>❒ Weak<br>❒ Normal/Bedrest/Immobile | 20<br>10<br>0 |
| Secondary Diagnosis | ❒ Yes<br>❒ No | 15<br>0 | Mental Status | ❒ Forgets Limitations<br>❒ Oriented to Own Ability | 15<br>0 |
| Ambulatory Aid | ❒ Furniture<br>❒ Crutch/Cane/Walker<br>❒ None/Bedrest/Wheelchair/Nurse | 30<br>15<br>0 | | **TOTAL** | |
| IV/Saline Lock | ❒ Yes<br>❒ No | 20<br>0 | 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

Volume/Frequency: _____ ❒ Special Diet: _____

### 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***

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

## 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

| Preferred Learning Style | Potential Barriers to Learning | | Learning Needs | |
|---|---|---|---|---|
| ❒ Visual | ❒ None | ❒ Emotional | ❒ Diagnosis | ❒ Safe Use of Equipment |
| ❒ Written | ❒ Desire/Motivation | ❒ Cultural | ❒ Medications | ❒ Community Resources |
| ❒ Demonstration | ❒ Physical Limitations | ❒ Spiritual | ❒ Nutrition/Diet | |
| ❒ Learning Deficiency: _____ | ❒ Limited Learning Ability | ❒ Religious | ❒ Self Care Needs / Management | |
| ❒ Other _____ | | | ❒ Other: _____ | |

## 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 thru Section XII** **Completed by:** _____ (signature) (title) **Date/Time:** _____

*** PLACE REFERRAL TO APPROPRIATE DISCIPLINE**