ADMISSION ASSESSMENT AND HISTORY PEDIATRICS

Date/Time of Admission ☐ See Notes ☐ Verification of patient ID band

Mode of Arrival to unit ☐ Carried ☐ Wheelchair ☐ Walked
☐ Other:

Accompanied by:	**Language(s) Spoken** ☐ En ☐Fr ☐ Other: ☐ Translator required

Source of information ☐ Self ☐ Family ☐ Other:	**Age**
Diagnosis/Procedure **Date Booked:**	☐ **Consult** ☐ **Consent** *on patient record*

Key Contact: *(name, relationship, ph#)* ☐ Parent ☐ Personal Guardian
Copy of document ☐ Personal Guardian

Allergies: *(describe reaction(s))* ☐ None Known
☐ Medi Alert on ☐ Agency Alert on
☐ Facility specific Allergy/Intolerance record completed *(if applicable)*
☐ Drug:
☐ Food:
☐ Latex:
☐ Environment:

Advance Care Plan: Goals of Care completed ☐ Yes ☐ No ☐ On File Location: ______________________

Other Contacts: ***(name, relationship, phone #'s)***

	(H)	(W)	(C)
1.	**(H)**	**(W)**	**(C)**
2.	**(H)**	**(W)**	**(C)**
3.	**(H)**	**(W)**	**(C)**

	QUESTIONS	YES	NO	PATIENT'S RESPONSE AND INTERVIEWER'S COMMENTS
PERSONAL HYGIENE	**Child requires care** bathing			☐ Tub ☐ Shower ☐ Other:
	grooming			
	oral care			
	dressing			
	assistance provided			By: ☐ Family ☐ Home Care ☐ Day Care
	Devices with patient			Hearing aid(s) ☐ Rt ☐ Lt Braces ☐ U ☐ L Retainers: ☐ U ☐ L ☐ Loose Tooth *(specify)* ☐ Glasses ☐ Contact lens ☐ Other: ☐ With Patient ☐ At Home
ELIMINATION	**Bowel problems** *(describe problem and help needed)*			Bowel Pattern: Date of last BM:
	trained			Usual word/gesture used:
	Urinary problems *(describe problem and help needed)*			Type of Diaper:
	trained			Usual word/gesture used:
NUTRITION	**Specific diet** *(specify)*			
	Food intolerance/likes/ dislikes *(specify)*			
	Feeding method	☐ self ☐ assist ☐ fingers ☐ spoon ☐ other:	☐ cup ☐ breast ☐ bottle (type____________________) ☐ nipple (type____________________)	**Food type** ☐ formula ☐ purees ☐ jr. food ☐ finger food ☐ table food ☐ Other:
	Feeding schedule *(describe frequency and amount)*			Time and amount: last ate: last drank:
MOBILITY	**Physical development concerns** *(describe any problems)*			☐ rolls over ☐ sits up ☐ crawls ☐ walks
	Physical limitations *(describe help needed)*			
	Devices used			☐ Wheelchair ☐ Prosthesis: *(list)* ☐ Orthopedic: *(list)* ☐ With Patient ☐ At home

DO NOT COPY

OBSERVATIONS AND MEASUREMENTS

Temp °C		Pulse	Resp	BP	SpO2	Blood Glucose	Height	Weight	Pedal Pulse(s)	Head Circ	Birth Wt
	☐ Tympanic ☐ Axilla ☐ Rectal ☐ Oral	☐ Radial ☐ Apical		mmHg	%	mM/L	cm	kg	(R) (L)	cm	kg

Pain ☐Unable to verbalize pain
Provoked by:

Quality: ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Crushing ☐Intermittent ☐Occasional ☐Other:
Radiates/ Location:

Severity: 0 1 2 3 4 5 6 7 8 9 10
Time (when it started, how long it lasts):

Normal Findings	Abnormal Signs	History / Current Medical Conditions	Comments
CNS ☐	☐ Tremors ☐ Pupils unequal ☐ Dizziness ☐ Speech slurred ☐ Vertigo ☐ Paraplegia ☐ Unsteadiness ☐ Quadriplegia ☐ Disoriented ☐ Hemiplegia ☐ Memory loss ☐ Hemiparesis ☐ Headache ☐ Motor/Sensory loss ☐ Other:	☐ Seizure disorder ☐ Cerebral palsy ☐ Headaches ☐ Traumatic brain injury ☐ Other:	
CVS ☐	☐ Heart murmur ☐ Arrhythmias ☐ Cyanosis ☐ Tachycardia ☐ Edema ☐ Bradycardia ☐ Other:	☐ Anemia ☐ Rheumatic fever ☐ Blood disorder ☐ Other:	
Resp ☐	☐ Shallow ☐ Wheezing ☐ Rapid ☐ Cough ☐ Slow ☐ SOB ☐ Dyspnea ☐ Other:	☐ Asthma ☐ Pneumonia ☐ Bronchitis ☐ Frequent URI ☐ Other:	☐ Chest sounds clear ☐ Other:
GI ☐	☐ Flatulence ☐ Diarrhea ☐ Distension ☐ Nausea ☐ Herniation ☐ Emesis ☐ Obesity ☐ Indigestion ☐ Asymmetry ☐ Constipation ☐ Other:	☐ Bulimia ☐ Anorexia ☐ Umbilical hernia ☐ Stomach pain ☐ Other:	☐ See Elimination ☐ Bowel sounds normal x 4 quadrants ☐ Other:
GUR ☐	☐ Discharge ☐ Blood in urine ☐ Lesions ☐ Burning ☐ Other:	☐ Frequent UTI ☐ Menstrual problems ☐ Kidney problems ☐ Renal failure ☐ Other:	☐ See Elimination Pregnant ☐ Yes ☐ No ☐ NA LMP *(date)*
Integ ☐	☐ Bruising ☐ Rash ☐ Dry ☐ Lesions ☐ Pale ☐ Diaphoretic ☐ Abrasions ☐ Flushed ☐ Dehydrated ☐ Ulcer ☐ Jaundice ☐ Oily ☐ Pruritus ☐ Cyanosis ☐ Lumps ☐ Other:	☐ Eczema ☐ Bruises easily ☐ Other:	☐See Wound Record ☐History of Lice infestation: ☐ No ☐ Yes *(indicate most recent)*
MS ☐	☐ Swelling ☐ Limited ROM ☐ Deformities ☐ Spasms ☐ Weakness/Atrophy ☐ Amputation(s) ☐ Other:	☐ Scoliosis ☐ Pain: ☐ joint ☐ bone ☐ soft tissue ☐ Other:	☐ See Mobility Record
EENT ☐	☐ Deafness ☐ Facial paralysis ☐ Hoarseness ☐ Aphasia ☐ Blurred vision ☐ Discharge ☐ Nystagmus ☐ Conjunctivitis ☐ Tracheotomy ☐ Other:	☐ Hearing problems ☐ Tinnitus ☐ Otitis Media ☐ Vision problems ☐ Other:	
ENDO ☐	☐ Exopthalmia ☐ Glucosuria ☐ Enlarged tongue ☐ Polyuria ☐ Other:	☐ Diabetes Mellitus ☐ Other:	

Exposure to:	Yes	No	Comments
HIV			
Hepatitis			
TB			
Other:			

Treated for AROs:	Yes	No	Comments
VRE			
MRSA			
Other:			

☐ Facility ARO screening tool completed

DO NOT COPY

ADMISSION ASSESSMENT AND HISTORY
PEDIATRICS

OBS AND MEAS

	Yes	No	
Previous: *(if pertinent to this admission, where may they be obtained?)* X-rays			
Tests			
Hospitalizations *(when/where)*			Place of birth:
Communicable diseases			☐ Rubella ☐ Mumps ☐ Chicken Pox ☐ Measles ☐ Other:
Immunizations up to date *(if no, why not?)*			
Exposed to communicable disease(s) in past 3 wks *(specify)*			
Sepsis screening completed			☐ Positive ☐ Negative
Relevant medical conditions of parents/siblings *(describe)*			
Bleeding problems *(describe)* **patient**			
family			
Weight changes *(describe)*			

Patient's/Parent's description of present condition

History pertinent to this admission *(medical, surgical, trauma, etc. and dates)*

MEDS

Current Medications ☐ NA ☐ See Best Possible Medication History (BPMH)

Pharmacy of Choice *(Name and Location):*

	Yes	No	
IV/Parenteral therapy			

TX AND PRO

Previous blood transfusions *(describe when, why)*			
adverse reactions			
Presently receiving any treatment(s) *(describe, including discipline(s) providing care)*			☐ O_2 ☐ Trach Care ☐ Ventilator ☐ ROM ☐ Ostomy Care ☐ Skin/Wound care: *(specify)* ☐ Other: ☐ Complementary therapies: *(list)* Therapies ☐ Physiotherapy ☐ Occupational therapy ☐ Respiratory therapy ☐ Chiropractic ☐ Other:

TEACHING

Education *(grade and name of school)*			
Learning problems *(describe)*			

Assessment of patient's/parent's understanding of condition and related learning needs

DO NOT COPY

		Yes	No	
SAFETY	**Safety precautions required** *(describe)*			
PSYCHOSOCIAL	**Personal/home/school concerns** *(describe)*			☐ Recent changes ☐ Babysitter ☐ Mother working ☐ Other: ☐ Father working ☐ Day care
	Family/friends/agencies for support **Now**			☐ Will stay at night ☐ Will visit ☐ Will bring in supplies
	On discharge			☐ Home Care needed
	Religious/ethnic aspects that affect care			
	Clergy Visit			Affiliation:
	Diversional activities *(describe)*			☐ Soother ☐ Blanket ☐ Favorite toy: ☐ Activities
	Behavioural concerns *(describe)*			
	Fears *(describe)*			
	Bedtime routine *(describe)*			☐ Trouble getting to sleep ☐ Sleep Pattern: ☐ Frequent waking Time to bed: Time waking: Sleep in: ☐ Crib ☐ Toddler bed ☐ Co-sleep with caregivers Daytime naps: ☐ AM ☐ PM ☐ Other:
	Substance use ***(describe when, why)*** **Patient** **Alcohol**			☐ Last 24 hours? *(how much)* ☐ Smoking policy explained
	Tobacco			
	Illicit Drugs			
	Other:			
	Others in home **Alcohol**			
	Tobacco			
	Illicit Drugs			
	Other:			
	Parent's description of child's usual response to separation/stress			
	Assessment of emotional/behavioural status *(patient/parent)*			

Additional Comments:

Orientation to unit:	Yes	No
Layout		
Daily Routine		

If No, why not?

Disposition of belongings: ☐ See facility specific patient belongings form
☐ At bedside ☐ Taken home ☐ Locked up ☐ Other:

Date/Time:

IDs

DO NOT COPY