Affix Patient Identification Label

Paediatrics Admission Assessment Form

Admission Date & Time: _____

Admission Diagnosis: □	**Admission Source:**
	□ ER □ Clinics □ Other _____
Transported With: □	Admission Mode:
□ Oxygen □ Monitor □ IV □ Other _____	□ Walking □ Wheelchair □ Stretcher/Bed □ Other _____

Physician notified of arrival to unit: □ Yes □ No Time:_____

Reason:_____ **Physician's** Name: _____

Vital Signs ▸ BP_____ T _____ P_____ R _____SaO2_____

Height/Length _____cms Weight_____Kg Head circumference< 2yrs_____cm

Allergy/Adverse Reaction : ▸ □ None Known □ Yes Specify:□

_____ _____

Medication ▸ None □ Yes □ If yes:

Location of Medication ▸ At Home □ Given to Family □

How dose the child take medication best: □ Liquid □ Tablet □ Chewable □ Whole

Immunization History ▸ Not Known □ Known □ Up to date □ No □

Family History: □ NSF □ Heart Disease □ Hypertension □ Diabetes

□ Stroke □ Seizures □ Kidney disease □ Liver disease

Past Medical History: Obtained From ▸ Parent □ Other Family Member: □ Medical Records: □

Past Medical History	Past Surgical History	Last Hospital Admission

Breathing/Circulation	**NAD** □

Wheeze □ Apical Heart Rate: _____bpm Stridor □ Nasal Flaring □ □ Regular □ Irregular Cough □ Limbs: Pink □ Sputum □ Pale □ Mottled □	Comments: _____ _____ _____
Maintaining Body Temperature	**NAD** □
Pyrexia □ Hypothermia □	Comments: _____
Gastro Intestinal System:	**NAD** □
Abdomen Soft: □ Tenderness: □ Nausea/Vomiting □ Diarrhea: □ Constipation □	Comments: _____
Communication/ Neurological	**NAD** □
Behaviour/Communication inappropriate for age/ Stage development □ Unresponsive □ Drowsy □ Lethargy □	Comments: _____ _____ _____

Nutritional Screening Referral □ Date:_____	Self □ Assist □ Feed □
Arrange to refer to Dietician if any of the below apply Underweight □ Overweight □ Feeding Problem □ Special diet □ Special feeding method	**NAD** □ Comments: _____ _____ _____ _____ _____
Elimination	**NAD** □
□ Wear nappies □ Intermittent catheter □ Stoma □ Abdominal Distention	Comments: _____ _____ _____
Personal Cleanliness/ Skin	**NAD** □
Hair: Infestation □ Alopecia □ Eye: Discharges □ Mouth: Lesion □ Dry □ Teething □ Skin: Rash □ Bruising □ Breaks □ Drains □ Fistula □ Nappy Rash □	
Venous Access device: Yes □ No □ If yes: Type:_____ Location: _____ Date of Insertion:_____	Comments: _____ _____ _____
Mobilizing	**NAD** □
Weakness □ Abnormal gait □ Appliances / Aids □ Inappropriate for age □	Comments: _____ _____ _____

Sleep Pattern	**NAD** □

Difficulty Falling Asleep □ Difficulty Staying Asleep □ Not Rested After Sleep □

Sleep Routine : Bedtime ———— No. of Hours ———— Naps □ Comfort Item ————

Maintaining A Safe Environment	**Correct ID Band Applied** □
Physical Impairment □ Age dependency □ Infectious precautions □	Comments: ——————————— ———————————

Functional Screening: If patient needs assistance with any of the following, refer to rehabilitation □
Date:_____

□ Mobility in Bed □ Developmental Delay □ Walking

□ Transfers □ Musculoskeletal Congenital Abnormality **NA** □

Pain Screening:
Pain Score:_____ (if pain score more than 0 follow with pain assessment form)

Face, Legs, Activity,Cry,Consolability) FLACC Pain Scale)		
SCORING		
0	*1*	*2*
No particular expression or smile	*Occasional grimace or frown, withdrawn, disinterested*	*Frequent to constant quivering .chin, clenched jaw*
No position or relaxed	*Uneasy, restless, tense*	*Kicking or legs drawn up*
Lying quietly, normal position moves .easily	*Squirming, shifting ,back and forth, tense*	*.Arched, rigid or jerking*
(No Cry (Awake or asleep	*Moans or whimpers, occasional complaint*	*Crying, steadily, screams or sobs, frequent complaints*
Content relaxed	*Reassured by occasional touching hugging or talking*	*Difficulty to console or comfort*

Psychosocial

Unusual concerns about patient's Psychological Status: Yes □ No □

Physician Notified: ———————— (Date/Time)

Social History

Lives With ————————————————————
Siblings in house hold □ Yes □ No (if yes How Many?)————————————

Orientation To Unit:

Unit/Routine Bed Control/Rails	□ □	Telephone Calls □ Call Bell in reach □ Toilet Facilities □ Waste Disposal Explained □ Other;_____

All Information Obtained From ▸ Mother □ Father □ Other Family Member□ Medical Records □

Nurse's Name & ID:		
Date:	**Time:** *(eg:1200H)*	**Signature:**