

PEDIATRIC ASSESSMENT FORM	<div style="text-align: right; font-size: small;">Affix Label Here (If Available)</div> <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">_____</div> <div style="width: 60%;">Patient Name</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;">MR _____</div> <div style="width: 60%;">Number</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;">_____</div> <div style="width: 60%;">ID Card Number</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;">_____</div> <div style="width: 60%;">DOB</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;">_____</div> <div style="width: 60%;">Nationality</div> </div>
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Date / Time of Assessment: _____

Reason for Assessment: _____

Clinical Diagnosis: _____

Child's nickname (what the parents/family call them): _____

Mother's name: _____ Father's name: _____

Contact Numbers: _____

Carer / Guardian's Name (if different from parents): _____

Can either parent read or write English: Yes No

Section I

Source of Information: Patient Family Others Specify: _____

S I G N I F I C A N T H I S T O R Y	<p>Post/Present Health History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Previous Hospitalization:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Family History:</p> <p>: _____</p> <p>_____</p> <p>_____</p> <p>Was your child's birth normal? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please describe the problems) _____</p> <p>Has your child or close family member had recent contact with a communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list what disease and date of contact: _____</p> <p>Does your child have any other problems with their physical or mental health? (If yes, please describe): _____</p> <p>_____</p> <p>Are your child's immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No Catch up immunizations required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Catch up immunizations required Please list: _____</p> <p>Does your child have any social or behavioral problems? (Eg. ADHD, poor social skills, learning difficulties, etc.,)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe): _____</p> <p>_____</p> <p>_____</p>
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CURR ENT T M ED IC AT IO NS	Medications <input type="checkbox"/> INO <input type="checkbox"/> No <input type="checkbox"/> Yes																																																								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Name</th> <th style="width: 15%;">Dose</th> <th style="width: 15%;">Frequency</th> <th style="width: 15%;">Duration</th> <th style="width: 15%;">Name</th> <th style="width: 15%;">Dose</th> <th style="width: 15%;">Frequency</th> <th style="width: 15%;">Duration</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Dose	Frequency	Duration	Name	Dose	Frequency	Duration																																																
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Comments: _____																																																									

AL LE RG IES & RE AC TI O NS	Please describe what your child is Allergic to and the symptoms of the allergy:
	Food: _____ _____
	Drugs: _____ _____
	Other: _____ _____

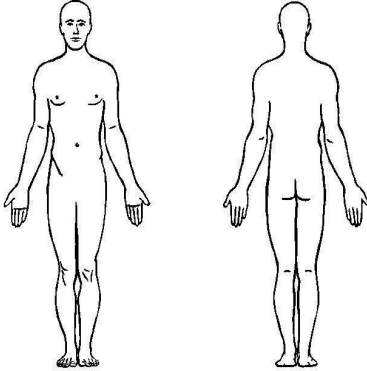
Section II (Assessment)

OBSERVATIONS:

TEMP: _____ PULSE: _____ RESPIRATION: _____ /min SaO2: _____

BP: _____ / _____ WEIGHT: _____ kg LENGTH/HEIGHT: _____ cm HEAD CIRCUMFERENCE: _____ cm

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O B S E R V A T I O N S O N A D M I S S I O N	PAIN: <input type="checkbox"/> Yes <input type="checkbox"/> No Pain Score: _____ (for pain assessment follow Pain Management Policy)																																															
	URINALYSIS OBTAINED: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A ALBUMIN: _____ SUGAR: _____ ACETONE: _____ <input type="checkbox"/> N/A																																															
	VISUAL APPEARANCE ON ADMISSION																																															
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	B = Burn																																															
	C = Contusion																																															
	D = Dislocation																																															
	F = Fracture																																															
	L = Laceration																																															
S = Swelling																																																
T = Tenderness																																																
BL = Bleeding																																																
																																																
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D A I L Y H A B I T S	DAILY EATING HABITS
	<input type="checkbox"/> Cup <input type="checkbox"/> Plate <input type="checkbox"/> Bottle <input type="checkbox"/> Breast <input type="checkbox"/> Dummy / Pacifier <input type="checkbox"/> Yes <input type="checkbox"/> No
	Formula: _____ Feeding Frequency / Amount: _____
	Diet: _____ Does your child need help to eat? <input type="checkbox"/> Yes <input type="checkbox"/> No
	(If your child needs help to eat please describe types of help required): _____
Food likes: _____ Food Dislikes: _____	
Elimination: <input type="checkbox"/> Wears Diapers? <input type="checkbox"/> Yes <input type="checkbox"/> No Toilet Trained: <input type="checkbox"/> Yes <input type="checkbox"/> No	

S L E E P H A B I T S	At home does your child sleep in a: <input type="checkbox"/> Bed <input type="checkbox"/> Crib Usual bedtime: _____
	Does your child usually sleep through the night? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how many times do they wake? _____
	Do you have a special bedtime routine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is it? _____
	Does your child have daytime sleeps? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list time(s) and duration: _____

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H Y G I E N E	<p>Does your child usually take a <input type="checkbox"/> Bath <input type="checkbox"/> Shower When (times of day): _____</p> <p>How often does your child wash their hair? _____</p> <p>Does your child clean their teeth independently? <input type="checkbox"/> Yes <input type="checkbox"/> No How many times per day? _____</p>
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Section III

FAMILY INFORMATION: Are there any other children in the family? (names and ages) _____

Name	Age	Name	Age
1.		4.	
2.		5.	
3.		6.	

S O C I O - E C O N O M I C P R O F I L E	<p>When your child is home, do you have:</p> <p><input type="checkbox"/> Good family support <input type="checkbox"/> Good support, other <input type="checkbox"/> Minimal support <input type="checkbox"/> No support <input type="checkbox"/> Not stated</p> <p>Many people find parenting difficult from time to time. Do you have concerns about parenting? (If yes, please describe)</p> <p>_____</p> <p>_____</p> <p>Do you or your partner smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarettes / Sheesha (if yes, how many per day?) _____</p> <p>Does your baby regular checkups? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Checkup? _____</p> <p>Does your child go to day care / pre-school? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list) _____</p> <p>_____</p> <p>What grade? _____ Is he/she is doing well in school? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>When your child is upset, what does he/she find most comforting? (eg. Read a story, give a hug?) _____</p> <p>Does your child have a favorite toy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there anything else we should know about your child/family to help us provide the best possible care? _____</p> <p>_____</p> <p>_____</p>
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Section IV

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O R I E N T A T I O N	<p>Orientation has been given regarding the following aspects:</p> <p><input type="checkbox"/> Patient Rights & Responsibilities <input type="checkbox"/> Infection Control Policy</p> <p><input type="checkbox"/> Home Safety <input type="checkbox"/> Medication Administration</p> <p><input type="checkbox"/> Care Emergency Policy <input type="checkbox"/> Health Education</p> <p><input type="checkbox"/> Bedside equipment <input type="checkbox"/> Referral</p> <p>Orientation given to: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Others Specify:</p> <p>_____</p> <p>Name of Person Orientation given to: _____ Signature: _____</p> <p>_____</p> <p><input type="checkbox"/> Orientation Not Given Reason: _____</p> <p>_____</p>
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END: N/A = Not applicable

MARKS:

Assessor Name: _____ Signature: _____ License _____

No.: _____

Date: _____ Time: _____