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PLACE LABEL HERE.
OCTOBER 2010 FORM NO. 080101
 IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PEDIATRIC ADMISSION SCREENING DATABASE

Initiated at: Date/time _____ Initiated by: Inpt Nurse Unit _____ ED SSU PETC/SAS Other _____

RN Name/Signature _____

Patient unable to answer questions at this time. No family available. Attempt 1. Date/time _____

Patient unable to answer questions at this time. No family available. Attempt 2. Date/time _____

Patient / Caregiver: To help us provide you with the best care please complete page 1 & 4 for the patient. The nurse will review this with you.

Who is providing information?: Patient From Medical Record

Family/Other (name/relationship) _____

CONTACTS – Parents:

Mother _____ Age _____ Phone Number: _____

Father _____ Age _____ Phone Number: _____

Married Unmarried Both parents involved? No *Yes

Legal Guardian _____ Age _____ Phone Number: _____

Name, Relationship & phone number(s) _____

Who should we call in case of an emergency? Name / phone (home /work / cell) / Relationship to patient _____

Who will take you home? (if different from legal guardian) _____

_____ (Written permission from legal guardian & photo ID required)

What is the name of the Doctor who referred you to UVa Medical Center? _____

*We encourage you to name one or two **Care Partners**. They may be parents, or primary care givers.*

Care Partners are people who are important to your care experience. They may be a part of your health care team, supporting you in the hospital and as closely involved in your care as you desire.

Would you like to identify one or two Care Partners? No *Yes

Care Partner #1 _____

Name / Relationship / Age / phone

Care Partner #2 _____

Name / Relationship / Age / phone

ABOUT YOU

Do you have allergies to environmental (cleaning solutions, perfumes, etc.) or latex/rubber products

No *Yes—List _____ Reaction: _____

Are your immunizations up to date? Yes No Not sure

Have you been exposed to any infectious diseases? Yes No Not sure

Have you had any infectious diseases (chicken pox, TB, flu)? Yes No Not sure

Menstruation? Yes No N/A Age of onset: _____ Date of last period: _____

Birth control? Yes No N/A Type: _____

Why are you being admitted to the hospital*? _____

What do you hope will happen*? _____

Do you have religious, cultural or spiritual beliefs that may affect care or treatment? No *Yes

Explain: _____

What is your primary language? English Other*: _____

Do you have any trouble with seeing or hearing? * Explain: _____

We will be teaching you new information. What would you like us to know about how you learn new things?* _____

Does your child have asthma and is your child currently wheezing or displaying symptoms like coughing or tight chest? *Yes No

Do you have an **Advance Medical Directive**? (Document which names a person to make medical decisions for you if you are unable) N/A (less than 18 years old) No Unknown *Yes – Document located:

*In hand *At home *In Medical Record

*Other: _____

Note: If you have questions about Advance Medical Directives, see our information booklet or ask a member of the health care team.

***RN action:**
 Provided CP Handout INFO 90051
 Gave CP ID Band
 CP info in Patient Profile
 Gave CP security code _____
 (Last 4 digits of Acct #)

***RN Action:**
 Allergy Armband placed
 Latex precaution in place
 Other: _____

***RN Action:**
 Addressed in Plan of Care
 Requested Chaplain visit
 Called 2-1794 for language needs
 Cyracom phone in use

***RN Action: If Yes –**
 Page resident on call to alert "Asthma Core Measures Patient"

***RN Action: If Yes –**
 reviewed with patient / placed copy in chart.
 checked Medical Record for copy
 asked family to bring copy

HEALTH HABITS Do you use Tobacco? No Quit on _____ *Yes Chew
 Smoke _____ packs/day for _____ years. *Our medical center building and grounds are smoke-free*
 Do you drink Alcohol? No Yes Beer Wine Spirits How often? How much? _____
 Do you use Recreational Drugs? No Yes Type/How often? _____
 Would you like information about quitting? *Tobacco *Alcohol *Drugs
 Does the caregiver use any of the following? Tobacco Alcohol Recreational Drugs
 Would you like information about quitting? *Tobacco *Alcohol *Drugs
 Where do you live/stay? At home In a facility - Name/Phone: _____
 Living arrangements: Alone with _____ *care for others

Other: _____
 Who will take you home? Name & Phone Number: _____
 Do you need help to get home? *Yes No

What pharmacy do you use? Phone: _____

Who is your primary doctor at home? _____

Do you have diabetes? No Yes

If yes, how do you take care of diabetes? Diet Pill Insulin Shot Insulin Pump

Do you test your blood glucose at home? No Yes

*What equipment or services do you currently use at home? None Oxygen Ventilator CPAP

Pulse Oximeter Nebulizer Apnea Monitor Cane Wheelchair Walker Crutches

Suction IV Pump Feeding Pump Other: _____

Do you currently receive services from: _____

*Medical Equipment Company Name/Phone: _____

*Home Health Agency Name /Phone: _____

*Community Services Agency Name /Phone: _____

HOSPITAL INFORMATION You receive a Patient Handbook on admission. We also have other information available about Safety, Visitation, Medication Management, Fall Prevention, etc. Please let us know if you have questions or need more information.

BELONGINGS You are responsible for **all** belongings left at the bedside. We strongly recommend you give your valuables and medications to someone to take home or have them put into our safe using a safekeeping envelope. Patients or designee must sign the safekeeping bag to retrieve items on discharge.

FOR THE ADMITTING RN: Check using 2 identifiers (name, date of birth, MRN, etc.) Complete as soon as possible with admission. Patient identity confirmed and armband on

As appropriate: Pt on Isolation – precaution education provided Allergy armband on Fall risk armband on

Belongings List – Note on admission and check at each permanent transfer

If in Bag, note –**P**-Pink or **G**-Green below

Vision: (P)	<input type="checkbox"/> None	<input type="checkbox"/> Contacts	<input type="checkbox"/> Glasses	<input type="checkbox"/> Other:
Hearing Aids: (P)	<input type="checkbox"/> None	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
Clothing: (G)	<input type="checkbox"/> None	<input type="checkbox"/> Dress	<input type="checkbox"/> Footwear	<input type="checkbox"/> Jacket/Coat
	<input type="checkbox"/> Pants	<input type="checkbox"/> Shirt	<input type="checkbox"/> Sweater	<input type="checkbox"/> Bathrobe
	<input type="checkbox"/> Socks	<input type="checkbox"/> Undergarments	<input type="checkbox"/> Pajamas	<input type="checkbox"/> Other
Toys:	<input type="checkbox"/> None	<input type="checkbox"/> Describe:		
Car seat:	<input type="checkbox"/> None	<input type="checkbox"/> Describe:		
Belongings given to:	<input type="checkbox"/> Patient	<input type="checkbox"/> Family -	<input type="checkbox"/> Other -	NAME:
Medications:	<input type="checkbox"/> Sent Home	<input type="checkbox"/> Sent to Pharmacy	<input type="checkbox"/> Stored on Unit for:	
	<input type="checkbox"/> Patient keeping			
Equipment at bedside:	<input type="checkbox"/> None	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker	<input type="checkbox"/> Crutches
	<input type="checkbox"/> CPAP	<input type="checkbox"/> Carseat	<input type="checkbox"/> Stroller	<input type="checkbox"/> Other:
Valuables: (G)	<input type="checkbox"/> None	<input type="checkbox"/> Including: Jewelry, Keys, Money/Wallet, Electronic Devices (laptop, cellphone, IPOD), etc. – Informed patient/family that they are responsible for belongings.		
Valuables given to:	<input type="checkbox"/> Safekeeping - Note	<input type="checkbox"/> Family (Name):	<input type="checkbox"/> Patient keeping	<input type="checkbox"/> Other (Name):
	# on Upper Right of Envelope:	<input type="checkbox"/> Other (Name):		

Patient/Caregiver Oriented to:

Room (i.e., Bed controls, Side rails, Call light, Whiteboard, Use of personal equipment and cell phone)

Hospital (i.e., Resources, Safety and Involvement, Visitation, Care Partners, Infection Control, Smoke-free Hourly Rounding, Family Activated Pert)

Reviewed and verified ALL information from Page 1 with patient/family Yes No – Comments: _____

RN name: _____ Date/Time: _____

>Initiate within 8 hours of admission >Enter referrals in MIS >Store in front of **Doorside** chart
 >Complete within 24 hours >Initiate Plan of Care >Receiving RN review with hand-off-of care (permanent transfer)

***RN action:**
 Handout provided PE#02001 (General) or PE#02017 (Smoking cessation)

***RN action:**
 Entered MIS referral for Social Worker
 Electrical medical equipment at bedside checked for safety

***RN action:**
 Referral to Diabetes Educator

BIRTH/MATERNAL HISTORY (For newborns only < 30 days)

Birth date/time: _____
Maternal: Age: _____ Gravida _____ Parity _____ Gestation _____ Blood Type _____ Antibody Screen _____
Infectious disease history: Hep B HIV GBS GC RPR Chlamydia Other _____
Maternal/pregnancy complications: _____
Birth: Type of delivery Vaginal C/S reason: _____
ROM date/time: _____ Meconium stain Oligohydramnios Polyhydramnios Chioamnionitis
Apgars: 1min _____ 5min _____
10min _____
Complications/Resuscitation: None Oxygen PPV Intubation Surfactant Chest compressions Meds
Other _____
Comments: _____

RN SCREENING: STRENGTHS & LIMITATIONS (Check all that apply)

LEARNING SCREENING

No needs / problems

Family: Language spoken? English Other:
How well does he/she speak English? Good Fair Poor/not at all
How well does he/she read English? Good Fair Poor/someone else completed the Database

Patient: Language spoken? English Other:
How well does he/she speak English? Good Fair Poor/not at all
How well does he/she read English? Good Fair Poor/someone else completed the Database

Barriers to Learning*: None Cognitive (memory loss, medical condition, learning disability)
Education/Literacy (Health literacy is the ability to read, understand and act on health care information)
Emotion/Motivation (Stress, anxiety, past experience, poor coping) Language/Culture (Need resources/interpreter?) Sensory (Poor hearing, vision; aphasia)
Other: _____

RN Action:
Interpreter notified when used, document name or cyra com#
Cyraphone to be used
Resources identified (culture, etc.)
Materials/Method to be adapted
Modify environment anticipated needs
Other _____

FUNCTIONAL/ DEVELOPMENTAL SAFETY SCREENING

No needs/problems

Newborns (<30 days)

<input type="checkbox"/> Preterm		<input type="checkbox"/> Term	
Grasp/hold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grasp/hold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Moves all extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Moro intact	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coordinated suck/swallow	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suck / swallow / gag	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to establish homeostasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visually track	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Respond to sound	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Focused alertness	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hand to face	<input type="checkbox"/> Yes <input type="checkbox"/> No

Minimal lift equipment needed for: Bed Mobility Transfer Ambulation None needed

All other > 30 days

Mobility: Holds head up Sits up Rolls Crawl Pulls to stand Cruises Walks Unable At baseline/developmental milestone: Yes No

Feeding: Breast Bottle Cup Feeds self Uses utensils At baseline/developmental milestone: Yes No

Language: Coos Single words Phrases Sentences Unable At baseline/developmental milestone: Yes No

School/social: Home Daycare Pre-school Grade____ Special Education At baseline/developmental milestone: Yes No

Behavior: Calm/cooperative Content Shy Irritable Temper Hyperactive Separation anxiety At baseline/developmental milestone: Yes No

Coping/Comfort Mechanisms

PAIN / COMFORT SCREENING

No needs / problems

Pain Needs / Problems Identified: Denies *Yes. If Yes — Acute pain management
Chronic pain management
Comfort needs (physical, psycho-spiritual, social, environmental) we need to address?
Denies *Yes. If Yes —
Non-pharmacologic comfort measures or Other _____

RN Action:
Based on needs/problems
Full Pain Assessment and Interviews

NUTRITIONAL / INTEGUMENTARY SCREENING

No needs / problems
Wt: _____kg Scale used: Infant Standing Bed Ht: _____cm HC (<2yr): _____cm
Usual diet/formula: _____
Plan to Breast feed (consider lactation consult)
*Special formula *Poor PO >5days *Poor wound healing *Burns >15%TBSA
*Problems chewing or swallowing *TPN/tube feeds *Diagnosis of malnutrition, FTT or new DM
*Need to see nutritionist during your stay
Other: _____

***RN Action:**
 Nutrition Screening entered into MIS
 HT/WT/AC entered into MIS

Ostomy: Will the patient be having ostomy surgery or have an ostomy? *Yes No

***RN Action:**
 Entered MIS Referral for Ostomy Team

VISITATION/CUSTODY SCREENING (*require Social Worker consult in MIS) No needs/problems

Are there any visitor restrictions? *Yes No If yes, explain _____
Are there any custody orders? *Yes No If yes, explain _____
Has a Security Risk Screen been done on this family *Yes No
Other: _____

***RN Action:**
 Entered MIS Referral for Social Worker

PSYCHOSOCIAL SCREENING

No needs / problems

*Problems with family situation stress *Current or recent physical violence or threat *Evidence of abuse / neglect / exploitation *Drug / alcohol use with a desire to quit *Unsafe physical environment / neighborhood
Running water Electricity Indoor toilet Telephone
Discharge needs: *Pharmacy *Transportation *Equipment/supplies Other: _____

Suicidal Ideation
RN Action:
Page MD

***RN Action:**
 Infection Prevention and Control Screening entered into MIS

INFECTION PREVENTION AND CONTROL SCREENING (based on patient or facility information)

No needs / problems

*Long-term isolation indicator present *Possibly infectious condition (acute cough, rash, diarrhea, etc.)
*History of isolation precautions at outside facility *History of MRSA, VRE, or Cdiff at outside facility
Other: _____

CRITICAL DISCHARGE FACTORS AND LIMITATIONS (Check all that apply) None

Multiple medications Multiple medical problems Children in foster care/DSS
Substance abuse Diagnosis developmental delay Newborns hospitalized since birth
Functional deficits Last admit w/in 60 days Ongoing home equipment
New diagnosis requiring significant parent teaching Other: _____

PATIENT / FAMILY STRENGTHS

Adequate home resources reported No known underlying chronic disease or disability
Family support system intact Able to effectively communicate needs to others
Able to meet basic self-care needs Able to participate in plan of care and decision-making
Able to identify own needs Other: _____

INITIAL PATIENT PLAN OF CARE See Clinical Pathway for Education and Plan of Care

Patient goals noted on Initial Clinical Data Flow Sheet/Critical Care Flowsheet

Implement interdisciplinary plan of care via the MIS Patient Treatment Plan (PTP).
Assist patient to participate in self-care activities and treatments.
Provide basic restorative services to support hygiene, sleep, nutrition and mobility needs.
Utilize adaptive services and devices to support motor/sensory/cognitive function needs.
Promote health maintenance behavior and appropriate preventive care activities.
Provide teaching to patient/family as needed during care and evaluate response.

Address Unique needs of patient/family including:

<input type="checkbox"/> Medications	<input type="checkbox"/> Physical	<input type="checkbox"/> Self-care
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Procedures / tests	<input type="checkbox"/> Wound care / skin integrity
<input type="checkbox"/> Pain management	<input type="checkbox"/> Psychosocial support (lodging finances)	<input type="checkbox"/> Discharge needs (transportation needs)
<input type="checkbox"/> Patient/family education/communication	<input type="checkbox"/> Safety/Mobility	<input type="checkbox"/> My Care Notebook given to family
<input type="checkbox"/> Isolation Teaching	<input type="checkbox"/> Family Activated PERT	<input type="checkbox"/> Asthma D/C Plan
<input type="checkbox"/> Other _____		

Initial plan of care and goals reviewed / discussed with patient/family.

NOTES:

Completed/Reviewed by: _____ Date/Time _____
RN Signature/Name/Initials _____