

PEDIATRIC ASSESSMENT FORM

Student: _____ **Faculty:** _____ **Date:** ____/____/____

Nurse: _____

Weight: _____ (Kg)

Scale: _____

Height: _____ (cm)

Head Circumference: _____ (cm)

Pain scale in use:

- FACES Rating Scale
- Numeric Rating Scale
- Objective Pain Scale

VITAL SIGNS:

Time	Temp	HR	R	BP	Pain Score	SPO2	Comments:

Hourly Checks On Patients	3 7	3 8	3 9	1 :	1 ;	4 2	4 3	4 4	4 5				
Initials													
Activity													
Family Present													
Bed Type													
Side Rails Up □X2 □X4													
Bed Position													
IV Fluids Checked													
Dressing Change													
Trach Care/ O2 Care													
Labs Drawn													
AM/PM Care													
Turned and Positioned (ROM)													
Linen Changed													
Enteral Feeding Bag Changed													
IV Tubing checked													

Code Key:

Position:
 Lt=Left
 Rt=Right
 P=Prone
 S=Supine
 IF=Infant Seat

H=Held

IV Tubing Checks:

✓=Secure
 *=See Focus Note

Family Present:

M=Mother
 Fa=Father
 O= _____
 Blank= No visitors

Bed Type:

Bd=Bed
 Cb=Crib
 C=Cage Top
 Iso=Isolette
 SB= _____

Activity:

BR=Bed Rest
 RP= Recreation/Play
 ChL=Child Life
 T/P=Test or Procedure (Identify in Comments)
 Amb=Ambulation
 Tv=watching TV
 SL=sleeping
 ScT=School Teacher

	Signature _____ Time _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Precautions: _____ <input type="checkbox"/> Arm Band on Patient Location _____
N E U R O	<input type="checkbox"/> Call bell within reach of Pt. or family <input type="checkbox"/> Alert <input type="checkbox"/> Appropriate for age/ condition <input type="checkbox"/> Lethargic <input type="checkbox"/> PEARLA <input type="checkbox"/> Cooperative <input type="checkbox"/> Combative <input type="checkbox"/> Apprehensive <input type="checkbox"/> Hyperactive <input type="checkbox"/> Other _____ Fontanel: <input type="checkbox"/> N/A <input type="checkbox"/> Open Soft Flat <input type="checkbox"/> Sunken <input type="checkbox"/> Full <input type="checkbox"/> Pulsatilla Speech: <input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Nonverbal <input type="checkbox"/> Inappropriate <input type="checkbox"/> Crying <input type="checkbox"/> Other _____ Motor: <input type="checkbox"/> Moves all extremities <input type="checkbox"/> Weakness _____ <input type="checkbox"/> Paralysis _____ <input type="checkbox"/> Comments _____
S K I N	Color: <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Jaundice <input type="checkbox"/> Flushed <input type="checkbox"/> _____ Temperature: <input type="checkbox"/> Warm <input type="checkbox"/> Cool Condition: <input type="checkbox"/> Intact <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Suture Line at _____ <input type="checkbox"/> Pressure area at _____ <input type="checkbox"/> Edema at _____ Turgor: <input type="checkbox"/> Normal <input type="checkbox"/> Tenting
I V	<input type="checkbox"/> IVF <input type="checkbox"/> No S/S Infiltration <input type="checkbox"/> No S/S Infection <input type="checkbox"/> CVL → Type _____ <input type="checkbox"/> Dressing D&I <input type="checkbox"/> PICC <input type="checkbox"/> EDC <input type="checkbox"/> PIV <input type="checkbox"/> Patent <input type="checkbox"/> D/C <input type="checkbox"/> Heplock Location: _____
C V	Rhythm: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Murmur Pulses: <input type="checkbox"/> Strong & equal at _____ + Unequal at _____ Capillary Refill Time _____ sec. Equipment: <input type="checkbox"/> None <input type="checkbox"/> Pacer wires <input type="checkbox"/> Monitored → Alarms set at _____ "
R E S P	<input type="checkbox"/> EBBS clear <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Irregular <input type="checkbox"/> Grunting <input type="checkbox"/> Stridor <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Cough → <input type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <input type="checkbox"/> Wheezing <input type="checkbox"/> Rales <input type="checkbox"/> Rhonchi <input type="checkbox"/> Coarse Location: _____ <input type="checkbox"/> O2 _____ <input type="checkbox"/> Vent <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Suction at Bedside <input type="checkbox"/> Pulse ox → Alarms set at _____ Sats _____ Comments: _____
G I	<input type="checkbox"/> Denies complaints <input type="checkbox"/> Mucus membranes pink & moist <input type="checkbox"/> Other _____ Abd. <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Tender <input type="checkbox"/> Distended Bowel Sounds: <input type="checkbox"/> Normal <input type="checkbox"/> Absent <input type="checkbox"/> Hyperactive <input type="checkbox"/> Hypoactive <input type="checkbox"/> Passing flatus <input type="checkbox"/> BM in past 24 hours. <input type="checkbox"/> Diapered <input type="checkbox"/> Incontinent <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Ostomy _____ <input type="checkbox"/> G-Tube <input type="checkbox"/> NGT → <input type="checkbox"/> Clamped <input type="checkbox"/> Feeds <input type="checkbox"/> Gravity <input type="checkbox"/> Suction <input type="checkbox"/> Feeding Pump Comments: _____
G U	<input type="checkbox"/> Voiding without difficulty <input type="checkbox"/> Other _____ " Af kcr gtgf "" "Ostomy """""" Urine: <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Color _____ <input type="checkbox"/> Anuric <input type="checkbox"/> Dialysis → <input type="checkbox"/> Today <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> In/Out Cath <input type="checkbox"/> Foley Care <input type="checkbox"/> Foley D/Cd → Voided _____ #hours Comments: _____
P A I N	<input type="checkbox"/> Denies c/o pain No signs/ symptoms <input type="checkbox"/> C/O pain → Location: _____ <input type="checkbox"/> New Pain <input type="checkbox"/> Pain NOT related to C/C <input type="checkbox"/> Intensity: _____ <input type="checkbox"/> Numeric <input type="checkbox"/> OPS <input type="checkbox"/> FACES <input type="checkbox"/> Pain well controlled on current regimen <input type="checkbox"/> Intermittent med <input type="checkbox"/> PCA <input type="checkbox"/> Epidural <input type="checkbox"/> Ineffective pain control

INTAKE

	15	16	17	18	19	20	21	22	Total
Nutrition/Facts									
PO									
Residual									
Tube									
IVF-1/ Site / Hour Total									
IVF-2 Site/Rate Hour Total									
IVF-3 Site/Rate Hour Total									
IVF-4 Site/ Hour Total									

Type of Intravenous Fluids:

- #1. _____
- #2. _____
- #3. _____
- #4. _____

OUTPUT

URINE	BM	FOLEY	NGT	DRESSING	EMESIS	DRAINS

Stool:
BK=Black
BR=Brown
Y=Yellow
G=Green
CC=Clay color
L=Liquid
LO=Loose
MU=Mucoid
W=Watery

- 1. I/O for 24 hours _____
- 2. I/O for shift _____