

Student Name: Abigail Lara Unit: PICU Pt. initials: N/A Date: 5/25/2021

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
<b>Appearance:</b> <input checked="" type="checkbox"/> Healthy/Well Nourished <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept <b>Developmental age:</b> <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed	<b>Pulse:</b> <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input checked="" type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ <b>Edema:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Location _____ <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <b>Capillary Refill:</b> <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec <b>Pulses:</b> Upper R <u>2+</u> L <u>2+</u> Lower R <u>2+</u> L <u>2+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>Social Status:</b> <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious <b>Social/emotional bonding with family:</b> <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent
<b>NEUROLOGICAL</b> <b>LOC:</b> <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input checked="" type="checkbox"/> Unresponsive <b>Oriented to:</b> <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input type="checkbox"/> Appropriate for Age <u>N/A</u> <b>Pupil Response:</b> <input type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input checked="" type="checkbox"/> Size <u>7mm</u> <b>Fontanel:</b> (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed <u>N/A</u> <b>Extremities:</b> <input type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right _____ Left _____ Pushes: Right _____ Left _____ S=Strong W=Weak N=None <b>EVD Drain:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ <b>Seizure Precautions:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>anoxic brain injury pt at baseline neuro/musculoskeletal</u>	<b>ELIMINATION</b> <b>Urine Appearance:</b> <u>yellow</u> <b>Stool Appearance:</b> <u>N/A</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	<b>IV ACCESS</b> <b>Site:</b> _____ <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <b>Type/Location:</b> _____ <b>Appearance:</b> <input type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return <b>Dressing intact:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fluids:</b> _____
<b>RESPIRATORY</b> <b>Respirations:</b> <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored <b>Breath Sounds:</b> Clear <input type="checkbox"/> Right <input type="checkbox"/> Left Crackles <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Wheezes <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Room Air <input type="checkbox"/> Oxygen <b>Oxygen Delivery:</b> <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: <u>Trach 2.0 HFNC</u> <b>Trach:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Size <u>4.0</u> Type <u>Bivona</u> Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Cough:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>No cough reflex</u> <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive <b>Secretions:</b> Color <u>White</u> Consistency <u>thick mucoid</u> <b>Suction:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>MI</u> <b>Pulse Ox Site:</b> <u>Left thumb</u> <b>Oxygen Saturation:</b> <u>94%</u>	<b>GASTROINTESTINAL</b> <b>Abdomen:</b> <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded <b>Bowel Sounds:</b> <input checked="" type="checkbox"/> Present X <u>4</u> quads <input checked="" type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent <b>Nausea:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>Vomiting:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Passing Flatus:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Tube:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>G/S tube</u> Location <u>LL abd</u> Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	<b>SKIN</b> <b>Color:</b> <input checked="" type="checkbox"/> Pink <input type="checkbox"/> Flushed <input checked="" type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt <b>Condition:</b> <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic <b>Turgor:</b> <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds <b>Skin:</b> <input checked="" type="checkbox"/> Intact <input type="checkbox"/> Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Tears <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown Location/Description: _____ <b>Mucous Membranes:</b> Color: <u>pink</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	<b>NUTRITIONAL</b> <b>Diet/Formula:</b> <u>Cont. Nubren Jr.</u> <b>Amount/Schedule:</b> <u>180 mL over 30 min</u> <b>Chewing/Swallowing difficulties:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <u>93H</u> <u>G-tube dependent</u>	<b>PAIN</b> <b>Scale Used:</b> <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces <b>Location:</b> _____ <b>Type:</b> _____ <b>Pain Score:</b> 0800 _____ 1200 _____ 1600 _____
	<b>MUSCULOSKELETAL</b> <input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input checked="" type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors <b>Movement:</b> <u>baseline</u> <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All <b>Brace/Appliances:</b> <input type="checkbox"/> None Type: _____	<b>WOUND/INCISION</b> <input checked="" type="checkbox"/> None <b>Type:</b> _____ <b>Location:</b> _____ <b>Description:</b> _____ <b>Dressing:</b> _____
	<b>MOBILITY</b> <input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <b>Assistive Device:</b> <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Bedridden	<b>TUBES/DRAINS</b> <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube <b>Site:</b> _____ <b>Type:</b> _____ <b>Dressing:</b> _____ <b>Suction:</b> _____ <b>Drainage amount:</b> _____ <b>Drainage color:</b> _____

NO IV access

CPOT = 0