

Situation

Chief Complaint / Diagnosis: history of vomiting and severe diarrhea X 3 days.

Parents brought patient to emergency department (ED) because she was not eating and was less active than usual. Transferred from ED to pediatric floor. Diagnosis - Gastroenteritis (viral vs. bacterial) with dehydration.

Allergy: NKDA **Code status:** Full code

Background

Latest Vital Signs: T 100.9 F, P 142, R 30, BP 80/50, SaO₂ - 95% on RA
admitting weight 10.5 kg

Medical History: otherwise healthy

Home Medications: none

RECENT History: Received a 210 ml bolus in emergency department (ED), nothing by mouth since ED admission. Urine output since bolus 35 ml dark amber in color.

Surgical History: none

Assessment

Assessment: Awake, fussy and not easily consoled. Lungs clear to auscultation.

Heart with regular rate and rhythm. Normal S1 S2 with a murmur heard on auscultation. Abdomen soft, non tender, active bowel sounds. Peripheral pulses equal x 4 extremities with no edema. Skin warm, dry, fair turgor. Mucous membrane tacky and pink. Excoriated rash to perineal area. Capillary refill 4 seconds.

IV D5 1/4NS + 20 meq KCL/liter @ 45 ml/hr

Lab

Glucose	110 *	60 - 100 mg/dL
Calcium	10.1	8.2 - 10.8 mg/dL
Sodium	147	138 - 146 mEq/L
Potassium	3.4 *	3.5 - 5.0 mEq/L
CO2	17	20 - 28 mEq/L
Chloride	95	98 - 106 mEq/L
BUN	20*	5 - 18 mg/dL
Creatinine	0.9*	0.3 - 0.7 mg/dL

Angela Garrett 1 yr F

WBC	10.0	5.5 - 15.5 x 10 ⁹ /L
Hgb	15.1	11.5 - 15.5 g/dL
Hct	44.2	35 - 45%
Platelets	281	150 - 400 x 10 ⁹ /L

Date/Time Note progress of case, complications, change in diagnosis on discharge, instructions to patient.

1 yr. old female admitted through ED with gastroenteritis. Parents report 3-day Hx of vomiting/diarrhea with low grade fever at home. Patient is Reported to be more listless today.

PMH: term gestation, APGAR 8/9, BW 4000 gms. No hospitalizations - occasional cold. Immunizations UTD.

Social: lives at home with Mom, Stepdad, one older sibling, all are healthy

PE: T 101 F P 146 R 30 BP 76/50

Gen: awake, fussy, not easily consoled

Lungs: CTA bilat. No retractions

HEENT: RRR, normal S1 S2

ABD: soft, nontender, no masses, + bowel sounds

EXT: no edema, cap refill 3-4 secs, pulses equal X 4

Skin: warm, dry, fair turgor. Mucous membranes tacky, pink. Rash to perineum.

DX: Gastroenteritis (viral vs. bacterial): dehydration

PLAN: admit, VS q 4, strict I & O

Labs drawn - CBC, BMP, UA

Need stool culture

NPO except meds

Tylenol, Desitin, IV fluids, Rocephin