

Janel

Pediatric ED Reflection Questions

1. Full body seizures, RSV, stomach pain, fall
What types of patients (diagnoses) did you see in the PED?
2. The majority of the patients who came in to the PED were from which age group? Was this what you expected? ^{age varies between} infant, preschool school age
3. Was your overall experience different than what you expected? Please give examples. ^{most came in for minor things} slow today I expected more kids coming in for any respiratory issue but it was didn't see much
4. How did growth and development come into play when caring for patients (both in triage and in treatment rooms)?
5. What types of procedures did you observe or assist with?
6. What community acquired diseases are trending currently? strep
7. What community mental health trends are being seen in the pediatric population?
8. What patient population is the most vulnerable? chronically ill patients, disabled, pt. w/ mental health problems
9. What is the process for debriefing after a traumatic event? ^{counseling} everyone meets up in the break room to talk about the situation & see who ever needs talk about things they could have done better
10. If someone donated \$100 million to the PED, what would you change? More staff, bigger rooms
11. What is the process for triaging patients in the PED? ^{level 3-5 treatment} sign in, assessment for the type of acuity they are based on level 1 as severe
12. What role does the Child Life Specialist play in the PED? they help pt. calm down, distract them for any traumatic experience educate

IM5 Clinical Worksheet – Pediatric Floor

<p>Student Name: Samuel Pivili Date: 11/15/23</p>	<p>Patient Age: 9 Patient Weight: 26.4 kg</p>
<p>1. Admitting Diagnosis: Brain Mass Olfuse intrinsic parane glioma</p>	<p>2. Priority Focused Assessment You Will Perform Related to the Diagnosis: peripheral neurovascular assessment Nerve assessment</p>
<p>3. Signs and Symptoms: personality changes muscle weakness balance disorder difficulty walking</p>	<p>4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: MRI Biopsy</p>
<p>5. Lab Values That May Be Affected: alkaline phosphatase 411U creatinine 0.14g iron 21g HDL 45g Vitamin D 123</p>	<p>6. Current Treatment (Include Procedures): Biopsy radiation treatment</p>
<p>7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient: 1. Distraction (playing board games, watching TV, etc.) 2. Music</p>	<p>8. Patient/Caregiver Teaching: 1. Make sure to always have someone when ambulating 2. Avoid sudden movements 3. Help perform daily ADL Any Safety Issues identified: None</p>

Student Name: Date:	Patient Age: 9 y. 0 d Patient Weight: 28.4 kg
9. Calculate the Maintenance Fluid Requirement (Show Your Work): $10 \times 100 = 1000$ $10 \times 50 = 500$ $8.4 \times 20 = 168$ $1000 / 24 = 41.5$ Actual Pt MIVF Rate: 70 ml/hr Is There a Significant Discrepancy Between Calculated and Actual Rate? NO If Yes, Why is There a Discrepancy?	10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): $28.4 \times 0.5 = 14.2$ Actual Urine Output During Your Shift (mL/hr): 13 ml/hr
11. Growth & Development: <ul style="list-style-type: none"> *List the Developmental Stage of Your Patient For Each Theorist Below. *Document 2 OBSERVED Developmental Behaviors for Each Theorist. *If Developmentally Delayed, Identify the Stage You Would Classify the Patient: <p>Erickson Stage: Industry versus Inferiority</p> <ol style="list-style-type: none"> 1. children feel some degree of inferiority regarding skills they can't master 2. child desires real achievement <p>Piaget Stage: concrete operational period</p> <ol style="list-style-type: none"> 1. classification & logic 2. reversibility 	
Please list any medications you administered or procedures you performed during your shift: Acetaminophen IV syringe	

Student Name: Janel Pinili Unit: _____ Pt. Initials: _____ Date: _____

Pediatric Medication Worksheet - Current Medications & PRN for Last 24 Hours

Allergies: No known Allergies

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?		Lab Values to Assess Related to IVF	Contraindications/Complications
				Is med in therapeutic range?	If not, why?		
Famotidine H2 antagonist	antihistamine	prevent ulcers in stomach	2mg/ml IV Q24hours	0.25-0.5mg/kg	yes	Na ⁺ K ⁺	Fever, cramping, headache, swelling
Acetaminophen	Analgesics	Pain reliever	10mg/ml IV Q6	10-15mg/kg per dose	yes		Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.) 1. Avoid sudden movement as it can cause dizziness 2. Make sure to have someone help you ambulate 3. Call HCP if you have difficulty breathing 4. May experience constipation/diarrhea 1. May cause swelling in your hands/ankles 2. May experience itching 3. May cause blistering skin 4. May cause hoarseness
Dexamethasone	glucocorticoids	Treat inflammation	4mg/ml IV Q6	0.02-0.3mg/kg	yes		1. May cause increase hair growth 2. May see changes in appetite 3. Make sure to hydrate 4. May experience mood changes
							1. 2. 3. 4.
							1. 2. 3. 4.

Pediatric Floor Patient #1

NPO

PO/Enteral Intake		INTAKE/OUTPUT																
	07	08	09	10	11	12	13	14	15	16	17	18	Total					
PO Intake																		
Intake - PO Meds																		
Enteral Tube Feeding																		
Enteral Flush																		
Free Water																		
IV INTAKE																		
IV Fluid	70	70	70	70	70	70											Total	
IV Meds/Flush	20	20	20	20	20	20											470	
OUTPUT																		
Urine																		
# of immeasurable				50		100											Total	
Stool																	150	
Urine/Stool mix																		
Emesis																		
Other																		

Children's Hospital Early Warning Score (CHEWS)
(See CHEWS Scoring and Escalation Algorithm to score each category)

Behavior/Neuro	Circle the appropriate score for this category: 0 (1) 2 3
Cardiovascular	Circle the appropriate score for this category: 0 (0) 1 2 3
Respiratory	Circle the appropriate score for this category: 0 (0) 1 2 3
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>3</u>
	Score 0-2 (Green) - Continue routine assessments
	Score 3-4 (Yellow) - Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) - Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

Pediatric Floor Patient

old infant

hed kept	CARDIOVASCUL
	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thrill <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Local <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Capillary Refill: <input checked="" type="checkbox"/> < 2 s
ss	Pulses: Upper R <u>3</u> L _____ Lower R <u>3</u> L _____ 4+ Bounding 3+ _____ 1+ Intermittent _____
it	ELIM
qual	Urine Appearance _____ Stool Appearance _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody
Flat	GAS
d	Abdomen: <input type="checkbox"/> Distended
s	Bowel Sounds: <input type="checkbox"/> Active <input type="checkbox"/> No
rically	Nausea: _____ Vomiting: _____
regular	Passing Tube: _____ Lo: _____ <input type="checkbox"/>
ft	
eft	
eft	
Left	
/min	
@ _____ cm	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
productive	
ype _____	

(See
uro
ular
tory
ncern
concern
Total Score

Pediatric Floor Patient #2

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake		20		10		5							35
Intake – PO Meds													
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE													
IV Fluid	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT													
Urine	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine		25g			33g								58
# of immeasurable													
Stool													
Urine/Stool mix													
Emesis													
Other													

Children's Hospital Early Warning Score (CHEWS) (See CHEWS Scoring and Escalation Algorithm to score each category)	
Behavior/Neuro	Circle the appropriate score for this category: 0 1 2 3
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3
Respiratory	Circle the appropriate score for this category: 0 1 2 3
Staff Concern	1 pt - Concerned
Family Concern	1 pt - Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>0</u>
	Score 0-2 (Green) – Continue routine assessments
	Score 3-4 (Yellow) – Notify charge nurse or LIP, Discuss treatment plan with team, Consider higher level of care, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications
	Score 5-11 (Red) – Activate Rapid Response Team or appropriate personnel per unit standard for bedside evaluation, Notify attending physician, Discuss treatment plan with team, Increase frequency of vital signs/CHEWS/assessments, Document interventions and notifications

Pediatric Floor Patient #1

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input type="checkbox"/> Healthy/Well Nourished <input checked="" type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept Developmental age: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Delayed	Pulse: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Thready <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____ Edema: <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+ Capillary Refill: <input checked="" type="checkbox"/> < 2 sec <input type="checkbox"/> > 2 sec Pulses: Upper R <u>13</u> L <u>13</u> Lower R <u>13</u> L <u>13</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Crying <input type="checkbox"/> Uncooperative <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Withdrawn <input type="checkbox"/> Hostile/Anxious Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input checked="" type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____ Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>S</u> Left <u>S</u> Pushes: Right <u>S</u> Left <u>S</u> S=Strong W=Weak N=None EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>Clear</u> Stool Appearance: <u>Normal</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <u>22g Right arm</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>Right arm</u> Appearance: <input checked="" type="checkbox"/> No Redness/Swelling <input type="checkbox"/> Red <input type="checkbox"/> Swollen <input type="checkbox"/> Patent <input type="checkbox"/> Blood return Dressing Intact: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Fluids: <u>D5NS + 20 KCL</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) _____ <input type="checkbox"/> Labored Breath Sounds: Clear <input checked="" type="checkbox"/> Right <input checked="" type="checkbox"/> Left Crackles <input type="checkbox"/> Right <input type="checkbox"/> Left Wheezes <input type="checkbox"/> Right <input type="checkbox"/> Left Diminished <input type="checkbox"/> Right <input type="checkbox"/> Left Absent <input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input type="checkbox"/> BiPap/CPAP: _____ <input type="checkbox"/> Vent: ETT size _____ @ _____ cm <input type="checkbox"/> Other: _____ Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size _____ Type _____ Obturator at Bedside <input type="checkbox"/> Yes <input type="checkbox"/> No Cough: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Productive <input checked="" type="checkbox"/> Nonproductive Secretions: Color _____ Consistency _____ Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____ Pulse Ox Site _____ Oxygen Saturation: _____	Abdomen: <input type="checkbox"/> Soft <input checked="" type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X _____ quads <input type="checkbox"/> Active <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vomiting: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Passing Flatus: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tube: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Location _____ Inserted to _____ cm <input type="checkbox"/> Suction Type: _____	Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input type="checkbox"/> Natural for Pt Condition: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <input 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: _____ Mucous Membranes: Color: _____ <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
NUTRITIONAL	MUSCULOSKELETAL	PAIN
Diet/Formula: <u>NPD</u> Amount/Schedule: _____ Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Contracted <input type="checkbox"/> Weakness <input type="checkbox"/> Cramping <input type="checkbox"/> Spasms <input type="checkbox"/> Tremors Movement: <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All Brace/Appliances: <input checked="" type="checkbox"/> None Type: _____	Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: <u>0</u> 0800 _____ 1200 _____ 1600 _____
MOBILITY	WOUND/INCISION	TUBES/DRAINS
<input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist _____ Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____	<input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pediatric Floor Patient #2

5 day old infant

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

TIAL
 laxed
 ve
 less
 Anxi
 with
 well
 ds
 on
 n
 e
 e