

**Pediatric Floor Patient #2**

<p><b>GENERAL APPEARANCE</b></p> <p>Appearance: <input type="checkbox"/> Healthy/Well Nourished  <input type="checkbox"/> Neat/Clean <input type="checkbox"/> Emaciated <input type="checkbox"/> Unkept</p> <p>Developmental age:  <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Delayed</p>	<p><b>CARDIOVASCULAR</b></p> <p>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 _____</p> <p>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+</p> <p>Capillary Refill: <input checked="" type="checkbox"/> &lt; 2 sec <input type="checkbox"/> &gt; 2 sec</p> <p>Pulses:  Upper R <u>3+</u> L <u>2+</u>  Lower R <u>3+</u> L <u>3+</u>  4+ Bounding 3+ Strong 2+ Weak  1+ Intermittent 0 None</p>	<p><b>PSYCHOSOCIAL</b></p> <p>Social Status: <input 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 Withdrawn 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</p> <p>Social/emotional bonding with family:  <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</p>
<p><b>NEUROLOGICAL</b></p> <p>LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless  <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive</p> <p>Oriented to:  <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time/Event  <input checked="" type="checkbox"/> Appropriate for Age</p> <p>Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal  <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size _____</p> <p>Fontanel: (Pt &lt; 2 years) <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Flat  <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Closed</p> <p>Extremities:  <input checked="" type="checkbox"/> Able to move all extremities  <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically  Grips: Right <u>5</u> Left <u>5</u>  Pushes: Right _____ Left _____  S=Strong W=Weak N=None</p> <p>EVD Drain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Level _____</p> <p>Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>ELIMINATION</b></p> <p>Urine Appearance: _____</p> <p>Stool Appearance: _____  <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation  <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy</p>	<p><b>IV ACCESS</b></p> <p>Site: _____ <input type="checkbox"/> INT <input checked="" type="checkbox"/> None  <input type="checkbox"/> Central Line  Type/Location: _____</p> <p>Appearance: <input type="checkbox"/> No Redness/Swelling  <input type="checkbox"/> Red <input type="checkbox"/> Swollen  <input type="checkbox"/> Patent <input type="checkbox"/> Blood return</p> <p>Dressing Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fluids: _____</p>
<p><b>RESPIRATORY</b></p> <p>Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular  <input type="checkbox"/> Retractions (type) <u>Subcostal</u>  <input type="checkbox"/> Labored</p> <p>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</p> <p><input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Oxygen</p> <p>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: _____</p> <p>Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Size _____ Type _____  Obturator at Bedside <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Cough: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive</p> <p>Secretions: Color _____  Consistency _____</p> <p>Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____</p> <p>Pulse Ox Site: <u>O Hccl</u></p>	<p><b>GASTROINTESTINAL</b></p> <p>Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat  <input type="checkbox"/> Distended <input type="checkbox"/> Guarded</p> <p>Bowel Sounds: <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</p> <p>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</p> <p>Tube: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type _____  Location _____ Inserted to _____ cm  <input type="checkbox"/> Suction Type: _____</p>	<p><b>SKIN</b></p> <p>Color: <input type="checkbox"/> Pink <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced  <input type="checkbox"/> Cyanotic <input type="checkbox"/> Pale <input checked="" type="checkbox"/> Natural for Pt</p> <p>Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry  <input type="checkbox"/> Diaphoretic</p> <p>Turgor: <input type="checkbox"/> &lt; 5 seconds <input type="checkbox"/> &gt; 5 seconds</p> <p>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: <u>Diaper Rash</u></p> <p>Mucous Membranes: Color: <u>clear</u>  <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration</p>
	<p><b>NUTRITIONAL</b></p> <p>Diet/Formula: <u>Reg / Similac 260</u></p> <p>Amount/Schedule: _____</p> <p>Chewing/Swallowing difficulties:  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b>PAIN</b></p> <p>Scale Used: <input type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces</p> <p>Location: _____</p> <p>Type: _____</p> <p>Pain Score:  0800 _____ 1200 _____ 1600 _____</p>
	<p><b>MUSCULOSKELETAL</b></p> <p><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</p> <p>Movement:  <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> RL <input type="checkbox"/> LL <input checked="" type="checkbox"/> All</p> <p>Brace/Appliances: <input checked="" type="checkbox"/> None  Type: _____</p>	<p><b>WOUND/INCISION</b></p> <p><input checked="" type="checkbox"/> None</p> <p>Type: _____</p> <p>Location: _____</p> <p>Description: _____</p> <p>Dressing: _____</p>
	<p><b>MOBILITY</b></p>	<p><b>TUBES/DRAINS</b></p> <p><input checked="" type="checkbox"/> None  <input type="checkbox"/> Drain/Tube  Site: _____</p>

Oxygen Saturation: 97

Ambulatory  Crawl  In Arms  
 Ambulatory with assist \_\_\_\_\_  
 Assistive Device:  Crutch  Walker  
 Brace  Wheelchair  Bedridden

Type: \_\_\_\_\_  
 Dressing: \_\_\_\_\_  
 Suction: \_\_\_\_\_  
 Drainage amount: \_\_\_\_\_  
 Drainage color: \_\_\_\_\_

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INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake				25 mL									75 mL
Intake - PO Meds			0.79										0.79 mL
Enteral Tube Feeding													
Enteral Flush													
Free Water													
IV INTAKE	07	08	09	10	11	12	13	14	15	16	17	18	Total
IV Fluid													
IV Meds/Flush													
OUTPUT	07	08	09	10	11	12	13	14	15	16	17	18	Total
Urine													
# of immeasurable	1				1								2
Stool													
Urine/Stool mix			1										1
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: <input checked="" type="radio"/> 0   1   2   3
Cardiovascular	Circle the appropriate score for this category: <input checked="" type="radio"/> 0   1   2   3
Respiratory	Circle the appropriate score for this category: <input checked="" type="radio"/> 0   1   2   3
Staff Concern	<input checked="" type="radio"/> 1 pt - Concerned
Family Concern	1 pt - Concerned or absent
<b>CHEWS Total Score</b>	

