

Student Name: Davy Gomez

Unit: PEDI

Pt. Initials: R. G./M. M.

Date: _____

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

Allergies: NKA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
D5 NS + KCL 20	Isotonic/ Hypotonic/ Hypertonic	Hydration	K+, Na+, Cl-	Fluid overload, Hyperkalemia, Hyponatremia

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Therapeutic Range?	IVP – List diluent solution, volume, and rate of administration IVPB – List concentration and rate of administration	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
				Is med in therapeutic range?			
				If not, why?			
Oseltamivir (Tamiflu)	Influenza neuraminidase inhibitors	TX for the flu	84mg PO BID	3mg/kg/BID Yes	/	Behavior changes	-Avoid live vaccines 48hr after completion of treatment -Complete full prescribed schedule even when no symptoms are present - Report abnormal behavior changes -Make sure everyone in the house hold is vaccinated to prevent future infections
Erythromycin	ABX Marcolide	TX for mild-moderate URI	75mg IVPB Q8	15-20mg/kg/day Yes	75mg 103 ml/hr 20min	Hepatotoxic C.Diff	-Complete full prescribed schedule; Risk for drug resistant organism -Report abnormal changes in stool appearance; C.diff -It is highly encouraged to add a daily probiotic in your diet; reduces risk of normal flora destruction -Report abnormal skin changes such as jaundice, yellow sclera; hepatotoxic
							1. 2. 3. 4.
							1. 2. 3. 4.
							1. 2. 3. 4.

IM5 Clinical Worksheet – Pediatric Floor

Student Name: Davy Gomez Date:	Patient Age: 2mo Patient Weight: 2.94kg
1. Admitting Diagnosis: <p style="text-align: center;">Influenza</p>	2. Priority Focused Assessment You Will Perform Related to the Diagnosis: <p style="text-align: center;">Respiratory assessment</p>
3. Signs and Symptoms: Fever, chills, cough, sore throat, myalgia, headache, fatigue	4. Diagnostic Tests Pertinent to or Confirming of Diagnosis: <p style="text-align: center;">Nasopharyngeal swab</p>
5. Lab Values That May Be Affected: <p style="text-align: center;">WBC</p>	6. Current Treatment (Include Procedures): Antiviral medications : Oseltamivir (Tamiflu) Droplet precautions Increase fluid intake
7. Pain & Discomfort Management: List 2 Developmentally Appropriate Non-Pharmacologic Interventions Related to Pain & Discomfort for This Patient. 1. Pacifier use 2. Swaddle	8. Patient/Caregiver Teaching: 1. Importance of hand hygiene 2. Vaccinate house hold 3. Acetaminophen for fever or ibuprofen but no aspirin due to risk for Reye's syndrome Any Safety Issues identified: <p style="text-align: center;">Replaced dead batteries on temporal scope</p>

Student Name: Davy Gomez Date:	Patient Age: 2 mo Patient Weight: 2.94 kg
9. Calculate the Maintenance Fluid Requirement (Show Your Work): $2.94 \times 100 = \frac{294}{24} = \boxed{12.25 \text{ mL/hr}}$ Actual Pt MIVF Rate: <p>No, because we were replacing fluids orally</p> Is There a Significant Discrepancy Between Calculated and Actual Rate? If Yes, Why is There a Discrepancy? <p>N/A</p>	10. Calculate the Minimum Acceptable Urine Output Requirement (Show Your Work): 1 mL/kg/hr $1 \times 2.94 = \boxed{2.94 \text{ mL/hr}}$ Actual Urine Output During Your Shift (mL/hr): $\boxed{8 \text{ mL/hr}}$
11. Growth & Development: *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: Erickson Stage: Trust vs. Mistrust <ol style="list-style-type: none"> Mom feeding baby when he wanted Mom felt he was fussy because he was a little dirty so we sponge bathed him and he was very content afterwards Piaget Stage: Sensory motor <ol style="list-style-type: none"> When we were bathing him, he got a little upset. I placed his pacifier near his mouth and he began rooting/sucking I also placed my finger in his palm for fun-sies and he grasped it. 	
Please list any medications you administered or procedures you performed during your shift: <p>No meds were given during my shift nor was there any procedures.</p>	

GENERAL APPEARANCE	CARDIOVASCULAR	PSYCHOSOCIAL
Appearance: <input checked="" 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 checked="" 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+L 3+</u> Lower R <u>3+L 3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input type="checkbox"/> Quiet <input checked="" 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL		
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>fair</u> Fontanel: (Pt < 2 years) <input type="checkbox"/> Soft <input type="checkbox"/> Flat <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input checked="" type="checkbox"/> Closed Extremities: <input checked="" type="checkbox"/> Able to move all extremities <input checked="" 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	ELIMINATION Urine Appearance: <u>DARK/YELLOW</u> Stool Appearance: <u>BROWN/SOLID</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	IV ACCESS Site: <input checked="" type="checkbox"/> PALMART <input type="checkbox"/> None <input type="checkbox"/> Central Line <u>22g</u> Type/Location: <u>N/A</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>DS+KCL 20</u> <u>75/MLAR</u>
	GASTROINTESTINAL	SKIN Color: <input checked="" 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 Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <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: _____ Mucous Membranes: Color: <u>PINK</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
RESPIRATORY	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded Bowel Sounds: <input checked="" type="checkbox"/> Present X <u>4</u> quads <input type="checkbox"/> Active <input checked="" type="checkbox"/> Hypo <input type="checkbox"/> Hyper <input type="checkbox"/> Absent Nausea: <input checked="" type="checkbox"/> Yes <input 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 <u>N/A</u> Location <u>N/A</u> Inserted to <u>N/A</u> cm <input type="checkbox"/> Suction Type: <u>N/A</u>	PAIN Scale Used: <input checked="" type="checkbox"/> Numeric <input type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>N/A</u> Type: <u>N/A</u> Pain Score: 0800 <u>/</u> 1200 <u>0</u> 1600 <u>0</u>
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: <u>N/A</u> L/min <input type="checkbox"/> BiPap/CPAP: <u>N/A</u> <input type="checkbox"/> Vent: ETT size <u>N/A</u> @ <u>N/A</u> cm <input type="checkbox"/> Other: <u>N/A</u> Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>N/A</u> Type <u>N/A</u> 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 <u>N/A</u> Consistency <u>N/A</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> Pulse Ox Site: <input checked="" type="checkbox"/> HAND Oxygen Saturation: <u>98%</u>	NUTRITIONAL Diet/Formula: <u>REG DIET</u> Amount/Schedule: <u>N/A</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	WOUND/INCISION <input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
MUSCULOSKELETAL <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: <u>N/A</u>	MOBILITY <input checked="" type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input type="checkbox"/> In Arms <input type="checkbox"/> Ambulatory with assist <u>N/A</u> Assistive Device: <input type="checkbox"/> Crutch <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	TUBES/DRAINS <input checked="" type="checkbox"/> None <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pediatric Floor Patient #2

INTAKE/OUTPUT													
	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO/Enteral Intake													32
PO Intake							16	16					50
Intake – PO Meds						50							
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									300				300
# 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) 0 GREEN
	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 checked="" 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 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 <u>N/A</u> <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>2+</u> Lower R <u>3+</u> L <u>3+</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	Social Status: <input checked="" type="checkbox"/> Calm/Relaxed <input checked="" type="checkbox"/> Quiet <input checked="" 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 checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
NEUROLOGICAL	ELIMINATION	IV ACCESS
LOC: <input checked="" type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input type="checkbox"/> Sedated <input type="checkbox"/> Unresponsive Oriented to: <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time/Event <input checked="" type="checkbox"/> Appropriate for Age Pupil Response: <input checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>4mm</u> Fontanel: (Pt < 2 years) <input checked="" type="checkbox"/> Soft <input checked="" 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 checked="" 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 type="checkbox"/> No Level _____ Seizure Precautions: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Urine Appearance: <u>CLEAR/YELLOW</u> Stool Appearance: <u>YELLOW/BROWN</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <u>MUSHY</u> <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy	Site: <input checked="" type="checkbox"/> ANT-ANKLE <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line Type/Location: <u>N/A</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>N/A</u>
RESPIRATORY	GASTROINTESTINAL	SKIN
Respirations: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Retractions (type) <u>N/A</u> <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 type="checkbox"/> Room Air <input checked="" type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: <u>0.13L/min</u> <input type="checkbox"/> BiPap/CPAP: <u>N/A</u> <input type="checkbox"/> Vent: ETT size <u>N/A</u> @ <u>N/A</u> cm <input type="checkbox"/> Other: <u>N/A</u> Trach: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Size <u>N/A</u> Type <u>N/A</u> 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 <u>N/A</u> Consistency <u>N/A</u> Suction: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Type <u>N/A</u> Pulse Ox Site: <u>FOOT</u> Oxygen Saturation: <u>100%</u>	Abdomen: <input checked="" type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Guarded 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 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 <u>N/A</u> Location <u>N/A</u> Inserted to <u>N/A</u> cm <input checked="" type="checkbox"/> Suction Type: <u>OPPO NEO SUCKER</u>	Color: <input 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 Condition: <input checked="" type="checkbox"/> Warm <input type="checkbox"/> Cool <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic Turgor: <input checked="" type="checkbox"/> < 5 seconds <input type="checkbox"/> > 5 seconds Skin: <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: _____ Mucous Membranes: Color: <u>PINK</u> <input checked="" type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	NUTRITIONAL	PAIN
	Diet/Formula: <u>SOI-MULA / BF</u> Amount/Schedule: <u>0.3 PRN</u> Chewing/Swallowing difficulties: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> FLACC <input type="checkbox"/> Faces Location: <u>N/A</u> Type: <u>N/A</u> Pain Score: 0800 <u>N/A</u> 1200 <u>0</u> 1600 _____
	MUSCULOSKELETAL	WOUND/INCISION
	<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: <u>N/A</u>	<input checked="" type="checkbox"/> None Type: _____ Location: _____ Description: _____ Dressing: _____
	MOBILITY	TUBES/DRAINS
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Crawl <input checked="" type="checkbox"/> in Arms <input type="checkbox"/> Ambulatory with assist <u>N/A</u> 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 <input type="checkbox"/> Drain/Tube Site: _____ Type: _____ Dressing: _____ Suction: _____ Drainage amount: _____ Drainage color: _____

Pediatric Floor Patient #1

INTAKE/OUTPUT													
PO/Enteral Intake	07	08	09	10	11	12	13	14	15	16	17	18	Total
PO Intake	60		60										120
Intake – PO Meds		1.4											1.4
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					48								48
# of immeasurable					1								
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 <u>0</u>
Cardiovascular	Circle the appropriate score for this category: 0 1 2 3 <u>0</u>
Respiratory	Circle the appropriate score for this category: 0 1 2 3 <u>0</u>
Staff Concern	1 pt – Concerned
Family Concern	1 pt – Concerned or absent
CHEWS Total Score	
CHEWS Total Score	Total Score (points) <u>0</u> GREEN
	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