

PICU

Admit: 2/17

<b>GENERAL APPEARANCE</b> 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	<b>CARDIOVASCULAR</b> 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 checked="" type="checkbox"/> Yes <input 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>35</u> L <u>35</u> Lower R <u>2</u> L <u>18</u> 4+ Bounding 3+ Strong 2+ Weak 1+ Intermittent 0 None	<b>PSYCHOSOCIAL</b> Social Status: <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 Withdrawn 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 Social/emotional bonding with family: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent
<b>NEUROLOGICAL</b> LOC: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Restless <input checked="" 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 checked="" type="checkbox"/> Equal <input type="checkbox"/> Unequal <input checked="" type="checkbox"/> Reactive to Light <input type="checkbox"/> Size <u>2</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 type="checkbox"/> Able to move all extremities <input type="checkbox"/> Symmetrically <input type="checkbox"/> Asymmetrically Grips: Right <u>none</u> Left <u>none</u> Pushes: Right <u>none</u> Left <u>none</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 type="checkbox"/> No	<b>ELIMINATION</b> Urine Appearance: <u>yellow</u> Stool Appearance: <u>none</u> <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloody <input type="checkbox"/> Colostomy <u>W/FR Foley</u>	<b>IV ACCESS</b> Site: <u>OPIC 18G</u> <input type="checkbox"/> INT <input type="checkbox"/> None <input type="checkbox"/> Central Line <u>(2) Radial A-line</u> Type/Location: _____ 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: _____
<b>RESPIRATORY</b> 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 type="checkbox"/> Room Air <input type="checkbox"/> Oxygen Oxygen Delivery: <input type="checkbox"/> Nasal Cannula: _____ L/min <input checked="" type="checkbox"/> BiPap/CPAP: <input checked="" type="checkbox"/> Vent: ETT size <u>6.0</u> @ <u>21</u> 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Productive <input type="checkbox"/> Nonproductive Secretions: Color <u>white</u> Consistency _____ Suction: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Pulse Ox Site <u>2 pointer finger</u> Oxygen Saturation: _____	<b>GASTROINTESTINAL</b> 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 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 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type <u>OG</u> Location _____ Inserted to _____ cm <input checked="" type="checkbox"/> Suction Type: _____	<b>SKIN</b> Color: <input checked="" 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 checked="" type="checkbox"/> Cool <input 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: _____ <input type="checkbox"/> Moist <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Ulceration
	<b>NUTRITIONAL</b> Diet/Formula: <u>Pedia sure Pept</u> Amount/Schedule: <u>continuous</u> Chewing/Swallowing difficulties: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>1.5 kcal/oz 42 rate</u>	<b>PAIN</b> Scale Used: <input type="checkbox"/> Numeric <input checked="" type="checkbox"/> ELACC <input type="checkbox"/> Faces Location: _____ Type: _____ Pain Score: 0800 _____ 1200 _____ 1600 _____
	<b>MUSCULOSKELETAL</b> <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 checked="" type="checkbox"/> Tremors Movement: <input checked="" type="checkbox"/> RA <input type="checkbox"/> LA <input checked="" type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> All Brace/Appliances: <input type="checkbox"/> None Type: _____	<b>WOUND/INCISION</b> <input type="checkbox"/> None Type: <u>suture/incision</u> Location: <u>cranium</u> Description: <u>staples</u> Dressing: <u>no dressing</u>
	<b>MOBILITY</b> <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 checked="" type="checkbox"/> Bedridden	<b>TUBES/DRAINS</b> <input type="checkbox"/> None <input checked="" type="checkbox"/> Drain/Tube Site: <u>posterior cranium</u> Type: <u>EP</u> Dressing: <u>none</u> Suction: <u>half charged</u> Drainage amount: _____ Drainage color: <u>red</u>

CPAP Pass Pain scale