



Vanderbilt MONROE CARELL JR.

children's Hospital

Admission History / Discharge Plan (greater than 5 years)

Complete within 8 hours of admission

ARRIVAL DATE: ___/___/___ Time: _____

Ht: _____ Wt: _____ (Kg)

Admitted from: Admitting Office ED Clinic Other: _____

Primary Care Physician: _____

Information provided by patient / parent / other: _____

If other than patient, what is the relationship to this child? _____

What are the names of this child's legal guardians? _____

(If other than parent request copy of legal guardianship)

Will family be staying with patient No Yes Who: _____
Are there currently orders of protection or legal restriction on anyone who may want to visit? No Yes (if yes, request a copy of legal guardianship, orders of protection or restrictive visitation)

Patient's Nickname: _____

INFORMATION TO PLAN YOUR HOSPITAL STAY AND RETURN HOME: Can you read No Yes Can you write? No Yes

Primary Language English Spanish Other _____ Translator: _____

What brings you to the hospital today? _____

How long has this problem existed? _____ How do you care for it? _____

In an emergency, who do we contact? Name: _____ Relationship: _____ Phone: _____

Does the patient have other health problems? _____

Who will provide care when you leave the hospital? Name: _____ Relationship: _____

Who will need instruction about your care at home? Name: _____ Relationship: _____

How do you prefer instructions: Written Spoken Demo Video/TV Do you have challenges when learning? No Yes

Hearing problem Deaf R / L Vision Problem Glasses Trouble Speaking Other _____ Education Level _____

Who may this child be discharged to? Names: _____

Who will drive when you are ready to leave the hospital? Name: _____ Phone number: _____

Do you know about Tennessee's child restraint law? Yes No If No, information provided

DO YOU HAVE ALLERGIES TO MEDICINES, FOODS, OR OTHER MATERIALS? NO KNOWN ALLERGIES

ALLERGY	ALLERGIC RESPONSE

DO YOU TAKE OR USE ANY MEDICINES, VITAMINS, SUPPLEMENTS, or ALTERNATIVE THERAPIES? None

NAME	DOSE	ROUTE	TIMES TAKEN	COMMENTS

TELL US ABOUT PATIENT'S RECENT IMMUNIZATIONS AND EXPOSURES TO INFECTIOUS DISEASE:

Age specific Immunizations up to date No Yes

Influenza vaccine (date) _____ Date uncertain Never Received

Pneumovax vaccine (date) _____ Date uncertain Never Received

Tetanus vaccine (date) _____ Date uncertain Never Received

Recent exposure to TB: No Yes (date) _____ Describe exposure / treatment _____

Recent exposure to infectious disease: No Yes (date) _____ Describe _____

In the past 10 days has patient or close contact traveled within or outside of US? No Yes (where) _____

Smallpox vaccine: Patient: No Yes (date) _____ IF either within 30 days, Smallpox Vaccine Alert Ordered

Family Member living at home: No Yes (date) _____

Provider notified regarding immunization / exposure status
Name of Provider Notified: _____

TELL US ABOUT DAILY ROUTINES AND ACTIVITIES:

What are your hobbies or favorite things to do? _____
Where do you go to school? _____ What grade are you in? _____
Do you do anything special to get ready to sleep at night? _____
Are you a sound sleeper? Does anything bother your sleep? _____
Are there any problems going to the bathroom? _____ Menses: No Yes LMP: _____
If menses yes: Are you currently pregnant or breast feeding a baby? No Yes **PHARMACY NOTIFIED**
Do you have loose teeth / dental apparatus? _____

DOES PATIENT HAVE INPATIENT ORDERS FOR REHABILITATION SERVICES? No Yes **If Yes → no further functional screening required**

Does your child have a new problem: no new problem noted at this time
 that makes it difficult to stand or walk safely without assistance?
 with losing balance or falling?
 with transferring from lying to sitting, sitting to standing, getting from the bed to a chair?
 Has child had Physical Therapy services in the past 12 months?

* Is there evidence of a **new problem** that puts the patient at risk for getting skin sores or joint contractures of the lower extremities?

Does patient have condition/order that restricts participation in PT? No Yes **If Yes → must be medically cleared for PT screening**
 Physical Therapy Screen ordered if 1 or more positive finding

Does your child have a new problem: no new problem noted at this time

using arms or hands fully, particularly concerning fine motor coordination for activities such as handwriting?
 that affects independence in toileting, bathing, grooming, or dressing?
 that affects ability to feed self?
 Has child had Occupational Therapy services in the past 12 months?
 * Is there evidence of a **new problem** that affects the patient's safety awareness or judgment?

* Is there evidence of a **new problem** that puts the patient at risk for getting skin sores or joint contractures of the upper extremities?

Does patient have condition/order that restricts participation in OT? No Yes **If Yes → must be medically cleared for OT screening**
 Occupational Therapy Screen ordered if 1 or more positive finding

Does your child have a new problem: no new problem noted at this time

when feeding or swallowing?
 with memory, attention or sequencing?
 Has child had a head injury?
 Does child have difficulty communication or understanding?
 Does child have a **new tracheostomy tube** and need a speaking valve to communicate?
 Has child had Speech Therapy services in the past 12 months?
 * Is there evidence of a **new problem** with thinking that affects the patient's memory, orientation, or ability to solve problems?

Is patient alert, following commands, and able to participate in therapy? No Yes **If No → cannot participate in Speech Screening**
 Speech Therapy Screen ordered if 1 or more positive finding

DO YOU HAVE ANY SPECIAL NEEDS RELATED TO YOUR DIET? (Nutrition Screening)

no special nutrition needs noted at this time
 Follow special diet / nutritional supplement because of medical condition Appetite poor greater than 1 week
 Parent / guardian unable to shop/cook/prepare meals Weight loss / failure to gain weight Food allergies (document on pg 1)
 Nutrition support (ie. Tube feed/TPN) Impaired chewing / swallowing Intensive care unit patient
 Request / Need nutrition education **Nutrition Screening Consult ordered if 1 or more positive finding**

PERSON COMPLETING FORM (if other than RN) _____ **Relationship to Patient** _____

IS PAIN PART OF THE REASON PATIENT IS COMING INTO THE HOSPITAL TODAY? No Yes

Pain Screening (Indicate Scale): FLACC FACES NUMERIC (0 = no pain, 10 = worst pain)

Do you / does your child have pain now? No Yes; Score: _____ Pain in recent past? No Yes; Score: _____

If no current or recent past pain, skip this section

If pain scale score 4 or greater (moderate pain), complete the following:

- 1. Location: _____
- 2. Character (e.g. burning, aching) _____
- 3. Is there a pattern (e.g. time of day?) _____
- 4. Does the pain move (radiate)? No Yes; Where? _____
- 5. When did the pain begin? _____
- 6. What makes it better? _____
- 7. What makes it worse? _____
- 8. What else have you tried for relief? _____
- 9. How does the pain affect your life (e.g. ability to perform usual activities, work rest, sleep)? _____

If unable to rank pain, screen for nonverbal and physiologic signs of discomfort. Circle all the descriptors that apply.

Nonverbal: Moans Groans Grunts Cries Gasps Sighs Facial Grimace Wincing Clenched Teeth
Physiologic: Tachycardia Increased BP Tachypnea Dilated Pupils Vasoconstriction Diaphoresis

Pain management plan in place, intervention(s) completed Provider contacted for consultation / development of pain management plan

RN Signature _____ **Date/Time:** _____

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Page 3 and 4 to be completed by VCH Caregiver

 Do you have RELIGIOUS, CULTURAL, or ETHNIC practices that we should consider while you are in the hospital? No

 Yes (explain): _____

 Do you want clergy to visit you in the hospital? No Yes
 If yes, religious preference: _____

 Pastoral Care Consult Ordered

Social Work Screening:

- | | | |
|---|-----------------------------|------------------------------------|
| 1. Is the parent/caregiver absent on admission or unable to stay with the child? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 2. Is the patient, a child of teen parent(s)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 3. Is the patient in foster care? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 4. Do you currently, or have you ever had a child removed from your home or placed in DCS custody and/or foster care ? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 5. *Has there been any major stress in the family in the past 6 months (divorce, domestic violence, custody, death, etc)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 6. *Will the patient's medical problem(s) likely cause a change in the family's ability to care for the patient? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 7. *Does the patient have any coping, grief or end of life issues? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 8. *Is the patient living in a shelter? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 9. *Are there physical injuries that are inconsistent with the patient's history? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |

 Social Work Referral ordered if 1 or more positive finding

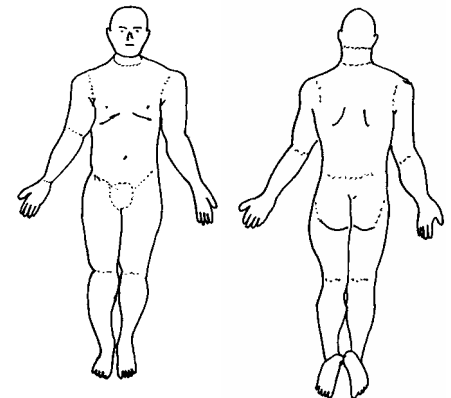
Case Management Screening:

- | | | |
|---|-----------------------------|------------------------------------|
| 1. Have you been in any hospital more than twice in the past 3 months? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 2. Do you currently use oxygen or medical equipment at home? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 3. Do you currently have a home health nurse visit you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 4. Have you had difficulty obtaining your medications? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 5. *Do you anticipate the need for home care services or medical equipment? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 6. *Do you anticipate the need for home infusions or enteral needs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 7. *Was patient admitted from an outside hospital or other facility? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 8. *Do you anticipate the need for self-injections at home? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |
| 9. *Are there other concerns that warrant a case manager consult? | <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ |

 Case Manager Referral ordered if 1 or more positive finding

Skin Risk Assessment

Braden Scale:	1	2	3	4	SCORE
SENSORY PERCEPTION	Completely Limited	Very Limited	Slightly Limited	No Impairment	
MOISTURE	Constantly Moist	Moist	Occasionally Moist	Rarely Moist	
ACTIVITY	Bedfast	Chairfast	Walks Occasionally	Walks Frequently	
MOBILITY	Completely Immobile	Very Limited	Slightly Limited	No Limitations	
NUTRITION	Very Poor	Probably Inadequate	Adequate	Excellent	
FRICION & SHEAR	Problem	Potential Problem	No apparent Problem		

Document ALL wound characteristics on Flowsheet and/or Complex Wound Form. Illustrate wound locations on diagram below.

NOTE: Refer to Braden Scale on Tri-fold or Assessment Guidelines page for complete descriptions of above terms.
Total Score: _____

 Provider notified of presence of pressure ulcers (all stages)
 Name of Provider Notified: _____

 Score equal to OR less than 16 - Initiate Pressure Ulcer Prevention and Treatment Protocol

 Stage III or IV pressure ulcer OR unstageable pressure ulcer - order WOC nurse consult

RN Signature _____ Date/Time: _____

Discharge Planning:											
Identified Needs:	Date	Action Taken								Initials	
Comfort											
Rehab Services (PT/OT/ST)											
Skin Risk											
Religious / Cultural Care											
Nutrition											
Infectious Disease											
Case Management											
Social Work											
Other											

Discharge Plan must be reviewed every 24 hours or by unit standards. If discharge plan reviewed and no changes made, circle date.

Signature	Init	Date	Date	Date	Date	Signature	Init	Date	Date	Date	Date