Admission History / Discharge Plan (less than 5 years)
Complete within 8 hours of admission

ARRIVAL DATE: _____/_____/_____ Time: _______________
Ht:_______ Wt:______(Kg) If less than 60 days, birth weight______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? 0 No 0 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

☐ Provider notified regarding immunization / exposure status
Name of Provider Notified: ______________________

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)_________
Family Member living at home: ☐ No ☐ Yes (date)_________

☐ ***IF either within 30 days, Smallpox Vaccine Alert Ordered***

TELL US ABOUT DAILY ROUTINES AND ACTIVITIES:

What are your child's favorite things to do / toys? ____________________

Where does your child go to school / daycare? ____________________ If so, what grade? ____________

Does your child do anything special to get ready to sleep at night? ____________________

Is your child a sound sleeper? _____ What bothers your child's sleep? ____________________

Does your child have loose teeth / dental apparatus? ____________________

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

☐ Has your child had Physical Therapy services in the past 12 months? **☐ no new problem noted at this time**

☐ Is there concern of a developmental delay (are they crawling, sitting, standing, walking)?

☐ * *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 an activity 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***

☐ Has your child had Occupational Therapy services in the past 12 months? **☐ no new problem noted at this time**

☐ Is there concern of a developmental delay (are they feeding self, bringing hands to mouth, sucking, tracking / eye contact)?

☐ * *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 an activity 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***

☐ Has your child had Speech Therapy services in the past 12 months? **☐ no new problem noted at this time**

☐ Do you feel your child's communication is inappropriate for their age?

☐ Does your child have difficulty with coughing, choking, feeding/swallowing or following instructions?

☐ Does your child have a new tracheostomy tube and need a speaking valve to communicate?

☐ Has your child had a head injury?

☐ * *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***

DOES YOUR CHILD HAVE ANY SPECIAL NEEDS RELATED TO DIET?

(Nutrition Screening)

☐ no special nutrition needs noted at this time

☐ Follow special diet / infant formula / nutritional supplement because of medical condition
☐ Appetite poor greater than 1 week
☐ Weight loss / failure to gain weight
☐ History of prematurity and less than 1 year of age
☐ Food allergies (document on pg 1)
☐ Nutrition support (ie. Tube feed/TPN)
☐ Parent / guardian unable to shop/cook/prepare meals
☐ Intensive care unit patient
☐ Request / Need nutrition education
☐ Impaired chewing / swallowing

☐ ***Nutrition Screening Consult ordered if 1 or more positive finding***

Feeding: ☐ Bottle Nipple Type ____________ ☐ Breast ☐ Sippy Cup ☐ Pacifier

Formula type / Schedule: ____________________ Solids: ____________________

☐ Mother having difficulty with lactation ☐ Mother requests / needs lactation education

☐ ***Lactation 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:____________________

Vanderbilt MONROE CARELL JR. Children's Hospital

Admission History / Discharge Plan (less than 5 years)

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:

Question	No	Yes
1. Is the parent/caregiver absent on admission or unable to stay with the child?	☐ No	☐ Yes ____________________
2. Is the patient, a child of teen parent(s)?	☐ No	☐ Yes ____________________
3. Is the patient in foster care?	☐ No	☐ 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 ?	☐ No	☐ Yes ____________________
*5. *Has there been any major stress in the family in the past 6 months (divorce, domestic violence, custody, death, etc)?*	☐ No	☐ Yes ____________________
*6. *Will the patient's medical problem(s) likely cause a change in the family's ability to care for the patient?*	☐ No	☐ Yes ____________________
*7. *Does the patient have any coping, grief or end of life issues?*	☐ No	☐ Yes ____________________
*8. *Is the patient living in a shelter?*	☐ No	☐ Yes ____________________
9. **Are there physical injuries that are inconsistent with the patient's history?*	☐ No	☐ Yes ____________________

☐ ***Social Work Referral ordered if 1 or more positive finding***

Case Management Screening:

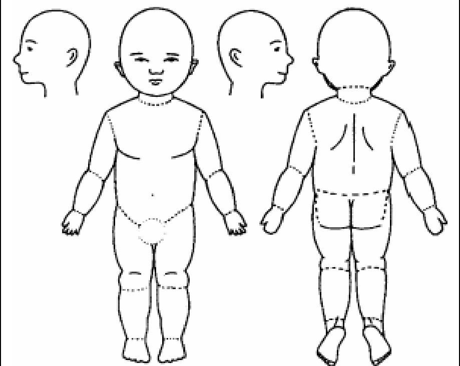
Question	No	Yes
1. Have you been in any hospital more than twice in the past 3 months?	☐ No	☐ Yes ____________________
2. Do you currently use oxygen or medical equipment at home?	☐ No	☐ Yes ____________________
3. Do you currently have a home health nurse visit you?	☐ No	☐ Yes ____________________
4.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

☐ **Case Manager Referral ordered if 1 or more positive finding**

Skin Risk Assessment

Braden Scale:	1	2	3	4	SCORE
MOBILITY	Completely Immobile	Very Limited	Slightly Limited	No Limitations	
ACTIVITY	Bedfast	Chairfast	Walks Occasionaly	Walks frequently/too young to walk	
SENSORY PERCEPTION	Completely Limited	Very Limited	Slightly Limited	No Impairment	
MOISTURE	Constantly Moist	Very Moist	Ocasionally Moist	Rarely Moist	
FRICTION & SHEAR	Significant Problem	Problem	Potential Problem	No Apparent Problem	
NUTRITION	Very Poor	Inadequate	Adequate	Excellent	
Tissue Perfusion & Oxygenation	Extremely Compromised	Compromised	Adequate	Excellent	
NOTE: Refer to Braden Scale on Tri-fold or Assessment Guidelines page for complete descriptions of above terms.				**Total Score:**	

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



☐	**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:	Action Taken	Initials
Comfort		
Rehab Services (PT/OT/ST)		
Skin Risk		
Religious / Cultural Care		
Nutrition		
Lactation		
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