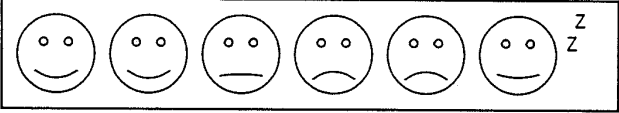


PAEDIATRIC INTENSIVE CARE UNIT - R.B.H.S.C.

NORMAL ROUTINE TAKEN FROM UNCLE.

NAME:- CONNOR MITCHELL		DoB:- 12/10/03		HOSP. NO:- 334505		DATE & TIME 04/05/03		NURSES SIGN:- S.BILL.	
RESPIRATORY NO PROBLEMS - NOT PRONE TO CHEST INFECTIONS.					PAIN/SEDATION Called for pain.				
<p>On Admission</p> Maintaining own airway ❖ Yes/No Method ❖ Self/oral airway/ET tube/tracheostomy Size & length of tube ❖ 65 cm ----- O2 Therapy ❖ Yes/No AcZ 30% Method ❖ Facemask/headbox/ventilator/T-piece Secretions ❖ Type & amount Specimen to lab ❖ Yes/No					<p>On Admission</p> Pain Relief Mode ❖ Yes/No - sedation/analgesia/paralysis ❖ PCA/infusion/epidural/oral or rectal preparation/intermittent  Use pain scale if appropriate				
CARDIOVASCULAR NO PROBLEMS.					NEUROLOGY Connor A bright alert young child. Expresses himself via facial expression + laughs.				
<p>On Admission</p> Colour/perfusion ❖ Pallor/cyanosis/well perfused Cardiac rate ❖ Bradycardic/tachycardic/normal Cardiac rhythm ❖ Sinus rhythm/arrhythmia Blood pressure ❖ Hypotensive/hypertensive/normal Drug therapy ❖ ----- Pacing wires insitu ❖ Yes/No Pacing box ❖ Sensing/pacing					<p>On Admission</p> CNS status ❖ Conscious/unconscious/irritable/drowsy Coma scale ❖ 3 ----- ICP monitor ❖ Yes/No - Type ----- Cervical collar ❖ Yes/No -----				
Temperature:- 36⁷		Heart Rate:- 137		Respirations:- 35		Blood Pressure:- 116/33		Weight:- EST 20kg	

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<p>NUTRITION/HYDRATION</p> <p>Eats a normal Diet.</p>	<p>HYGIENE/MOBILITY/WOUND CARE</p> <p>uses adapted buggy at home.</p>
<p>On Admission</p> <p>NUTRITION ASSESSMENT SCORE ()</p> <p>Nil By Mouth ❖</p> <p>Type of fluids insitu ❖</p> <p>B.M Stix 5-8 ❖</p> <p>Central line sites Lt femoral. ❖ Day No: 1</p> <p>Peripheral line site Lt radial RE Hara ❖ Day No: 1</p> <p>Arterial line site (L) brachial ❖ Day No: 2</p> <p>(L) subclavian *do not use*</p> <p>Nasogastric tube insitu ❖ Yes/No</p> <p>Gastrostomy tube insitu ❖ Yes/No</p>	<p>On Admission</p> <p>Skin Intact ❖ Yes/No</p> <p>Sites of</p> <ol style="list-style-type: none"> 1. Wounds <u>None</u> 2. Skin Breaks/Pressure Sores <u>nil</u> 3. Condition of Mouth <u>dry</u> 4. Condition of Eyes <u>clean</u> 5. Condition of Hair/Nails <u>clean</u> <p>Paralysed ❖ Yes/No</p> <p>Spontaneous Movements ❖ Yes/No</p> <p>Any Immobilising injuries/fractures ❖ Yes/No</p> <p>Site/s ❖</p>
<p>ELIMINATION</p> <p>Toilet trained.</p>	<p>PSYCHOLOGICAL/SOCIAL/CULTURAL</p> <p>lots of support from family.</p>
<p>On Admission</p> <p>Catheterised ❖ Yes/No Size: -8 Day No: 1</p> <p>Urinalysis ❖</p> <p>Date of last bowel motion ❖</p> <p>Wound Drain ❖ Yes/No Site: Day No:</p> <p>P.D. Cannula ❖ Yes/No</p> <p>Chest Drain ❖ Yes/No Site: Day No:</p> <p>Colostomy ❖ Yes/No</p> <p>Ileostomy ❖ Yes/No</p>	<p>On Admission</p> <p>Comfoter ❖ Yes/No</p> <p>Toys ❖ Yes/No <u>nil - tweezers</u></p> <p>Religion ❖</p> <p>Baptised ❖ Yes/NO</p> <p>CIRCUMSTANTIAL</p>

FAMILY NAME: <i>Mitchell.</i>		DATE: <i>09/05/03</i>	TIME: <i>7.15PM.</i>
FIRST NAME: <i>CONNOR</i> LIKES TO BE CALLED: <i>Connor.</i>		REASON FOR ADMISSION: <i>Observation of condition.</i>	PARENT(S)/CARER(S) RESIDENT? WHERE: [REDACTED]
CHILD'S ADDRESS: [REDACTED]		ACCOMPANIED BY: <i>Mum + Ambulance Staff.</i>	LIKES TO BE KNOWN AS: [REDACTED]
TELEPHONE NUMBER: [REDACTED]		WHY DO THE PARENTS THINK THE CHILD HAS BEEN ADMITTED? <i>for observation of condition.</i>	DO THEY WISH TO PARTICIPATE IN THE NURSING CARE OF THE CHILD? <i>When possible.</i>
AGE: <i>15 YRS</i> D.O.B.: <i>12/10/87</i> BIRTH WEIGHT: RELIGION: BAPTISED: <i>Yes/No</i>		MEDICAL DIAGNOSIS: <i>History of - Central palsy</i>	SOCIAL ARRANGEMENTS: [REDACTED]
NEXT OF KIN: <i>Joanna Mitchell.</i> RELATIONSHIP TO CHILD: <i>MOTHER</i> ADDRESS: [REDACTED]		PREVIOUS RELEVANT HISTORY/ADMISSIONS <i>X5 to RBHSC.</i> <i>MM</i>	
TELEPHONE NUMBERS: WORK: HOME:		CONSULTANTS: <i>Dr MS Kague.</i> <i>Dr Bohmell.</i>	NAME & AGE OF SIBLINGS <i>~LA</i>
WITH WHOM DOES THE CHILD RESIDE? <i>Mum.</i>			
RELATIONSHIP TO CHILD:			
WHO HAS PARENTAL RESPONSIBILITY FOR THE CHILD? [REDACTED]			
TELEPHONE NO:			
NAME OF SCHOOL/PLAYGROUP/NURSERY: <i>Teacher comes to home.</i>			

NAME OF G.P. Dr M. Wilson. ADDRESS: [REDACTED]		RECENT CONTACT WITH INFECTIOUS DISEASES? <i>nil</i>	OTHER RELEVANT INFORMATION
TELEPHONE NUMBER:		ALLERGIES: <i>nil</i>	
NAME OF HEALTH VISITOR: ADDRESS: TELEPHONE NUMBER:		CURRENT MEDICATIONS AND METHOD OF ADMINISTRATION: <i>/</i>	
SOCIAL WORKER/OTHER CONTACTS			
IMMUNISATIONS		ANY LOOSE TEETH	WARD FACILITIES - TICK BOX WHEN EXPLAINED TO PARENTS:
	DATE OR AGE ADMINISTERED	<i>no</i>	PARENTS ACCOMMODATION WITH NO SMOKING POLICY <input type="checkbox"/>
DIPHTHERIA	1st <input checked="" type="checkbox"/>		PARENT INFORMATION <input type="checkbox"/>
TET & POLO	2nd <input checked="" type="checkbox"/>		PARENT SHOWER/TOILET FACILITIES <input type="checkbox"/>
PERTUSSIS	3rd <input checked="" type="checkbox"/>	OTHER PROSTHESIS?	TELEPHONE <input type="checkbox"/>
MMR	<input checked="" type="radio"/> Yes <input type="radio"/> No	<i>no</i>	RESTAURANT/CANTEEN <input type="checkbox"/>
BOOSTER (pre school)	Yes/No	SIGNATURE OF NURSE TAKING HISTORY:	SOCIAL WORKER <input type="checkbox"/>
DIP.TET. POLIO	Yes/No	DATE:	CAR PARKING VOUCHERS <input type="checkbox"/>
B.C.G. administered		NAMED NURSE: <i>SN BILL</i>	
DATE OF LAST TETANUS			