مستشفى الواحة Oasis Hospital	**Form No: NSF30** **OUTPATIENT NURSING ASSESSMENT FORM – PEDIATRIC** **Nursing** **Prepared By: VPNS/ NMOPS** **Reviewed By: Asst. DON/Midwifery** **Approved By: Chief Executive Officer** **Issue Date: 01.Jan.2007** **Reviewed Date: 06 – 01.Mar.2014** **Next Review Date: 01.Jan.2016**	*Mahesh Sharma* **PATIENT STICKER**

Date/Time:	**Appointment?** ☐**No** ☐**Yes: Full outpatient assessment required?**
Reason for Visit	☐ No If Yes: ☐ New Patient ☐ Change in condition ☐ Last visit more than 12months

TEMP	PULSE	BP	RESP	SPO_2	WEIGHT	HEIGHT	HC

Allergy: □ **NKA** □ **Yes** **If yes, please specify**_____

Pain Assessment: (circle answer)

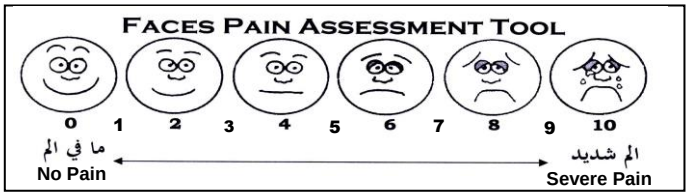
☐ **NIPS** (up to 1 year old)

Facial expression 0 1	**Cry** 0 1 2	**Breathing pattern** 0 1	**O_2 Saturation** 0 1
Arms 0 1	**Legs** 0 1	**Heart Rate** 0 1 2	**State of Arousal** 0 1

☐ **FLACC** (1year to 7 years old)

Face 0 1 2	**Legs** 0 1 2	**Activity** 0 1 2
Cry 0 1 2	**Consolability** 0 1 2	

☐ **FACES** Pain Scale
(above 7 years)



(If pain identified (1 or more) complete below information. If pain score is more than 4 - fill NSF35)

Location: _____ **Character code**:_____
Frequency (how often do you experience pain?) _____ **Pattern**: ☐ Constant ☐ Intermittent
Duration (how long have you had this pain?) _____
Radiation: ☐ No ☐ Yes (specify where)_____
Reassessment of pain based on triage level, document reassessment in Notes

Character codes: 1. Sharp 2. Dull 3. Stabbing 4. Burning 5. Crushing 6. Deep 7. Sore 8. Aching 9. Colic 10. Throbbing 11. Numb 12. Shooting 13. Pressing 14. Tight 15. Pulling 16. Squeezing

ESI Level 1 2 3 4 5 (not required for appointment patients)

Nurse Initial/ID _____

Screening for Influenza-like Illness

Does your child have sneeze/ cough/ have shortness of breath? ☐**No** ☐**Yes** *(offer patient mask as appropriate)*
Do your child have a fever or has been feeling feverish in the last 24 hours? ☐**No** ☐**Yes**
(Yes, or temp above 38°C) *(offer patient mask as appropriate)*

Nursing Notes

FULL PEDIATRIC OUTPATIENT ASSESSMENT

Language: ☐ Arabic ☐ English ☐ Other	**Accompanied by:** ☐ Parent ☐ Other
	Arrival: ☐ Walk ☐ Carried ☐ Other

Vaccination History

Routine Vaccines up to date: ☐Unknown ☐ Yes ☐ No (if 'no' circle which ones received)

Birth: BCG HBV
2 months: Hexavalent PCV Rotavirus
4 months: Hexavalent PCV Rotavirus
6 months: Hexavalent PCV
12 months: MMR Varicella
18 months: IVP/OPV Tetravalent PCV
4 to 6 years OPV MMR Varicella DTaP
Other Vaccines (if received circle and enter date)
Typhoid date: Hepatitis A date: Meningococcal date:
Yellow Fever date: Prevenar date:

Psychosocial and Economic History

☐Cooperative ☐Hyperactive ☐Uncooperative ☐ Depressed ☐ Angry ☐ Agitated ☐ Other_____
Living Situation: ☐ Family ☐ Other _____

Exposure to Infectious Disease (if yes, indicate disease and enter date)

☐ No Exposure

☐ Diarrhea Illness date: ☐ TB date: ☐ Meningitis date:	☐ Chicken Pox date: ☐ Measles date:

Nutritional Screening (Notify Physician if patient on special diet)

☐ Breast feeding ☐ Formula feeding ☐ Weaned (age)_____
☐ Normal Solids Diet ☐ Special Diet (specify):

Functional Screening

☐ Child less than 1 year of age – assessment omitted

Recent Change in Mobility Needs ☐ no ☐ yes Describe:

Category	Score	Describe if score 1 or 2	Category	Score	Describe if score 1 or 2
Feeding			Walking		
Toileting			Transfer		
Dressing			Mobility		

Score Key: **1** – Dependent **2** – Requires use of equipment **3** - Independent
(If any abnormal items notify physician)

Fall Risk and Intervention

All Pediatric patients are considered a fall risk, mark interventions used:

☐ Educate parent/carer to fall prevention interventions	☐ Do not leave child unattended on exam bed
☐ Assist in ambulation as needed	☐ Keep environment uncluttered and free of obstacles

Education

☐ no need identified
Care giver provided with education regarding:
☐ Use of medication ☐ Use of medical equipment ☐ Diet and nutrition
☐ Pain, and other symptoms management ☐ Others ----------

Nursing Notes

Nurse Initial/ID _____

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