D10323

Children's of Alabama
1600 7th Avenue South
Birmingham, AL 35233

«PatientNumber»

«AdmitDate» ECD #: «PatientNumber»
«PatientName»
MR#: «MedicalRecordNumber» LOC: «Location» «Room» «Bed»
«AttendingDoctorName» DOB: «BirthDate»

Nursing History - Patient Profile

General Information

How to be addressed ____

Spoken Language Preferred ☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian ☐ Korean ☐ Russian ☐ Sign ☐ Vietnamese ☐ Other___________________

Reading Language Preferred ☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian ☐ Korean ☐ Russian ☐ Sign ☐ Vietnamese ☐ Other___________________

Parental Spoken Language Preferred ☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian ☐ Korean ☐ Russian ☐ Sign ☐ Vietnamese ☐ Other____________

Parental Reading Language Preferred ☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian ☐ Korean ☐ Russian ☐ Sign ☐ Vietnamese ☐ Other____________

Source of information ☐ patient ☐ family ☐ significant other ☐ acute care facility ☐ chart(s) ☐ extended care facility ☐ foster care ☐ physician office ☐ inpatient rehabilitation facility ☐ unable to respond/no family available ☐ other __________________

Admitted From ☐ home ☐ acute care hospital ☐ ambulatory surgical center ☐ clinic ☐ correctional facility ☐ ED ☐ physician office ☐ referring hospital ☐ rehab facility ☐ residential facility ☐ school ☐ skilled nursing facility ☐ other __________________

General Info Comment ____

Body Measurements/Pain

Birth Weight (kg) ______ **(grams)** ______ **(pounds)** ______ **(ounces)** ______

Expression of Pain ☐ activity pattern change ☐ aggression ☐ agitated ☐ anorexia ☐ anxious ☐ arched/rigid ☐ body stiffness ☐ clenching teeth/lips ☐ contracted limbs ☐ crying ☐ eyes wide open ☐ flailing ☐ grimace ☐ jerking ☐ moaning ☐ muscle tension ☐ restless ☐ rocking ☐ rubbing ☐ sleep pattern change ☐ squirming ☐ verbal ☐ withdrawn

Chronic Pain? Yes/No If Yes: description of pain (frequency/quality) ☐ constant ☐ frequent ☐ intermittent ☐ occasional ☐ aching ☐ burning ☐ cramping ☐ crushing ☐ gnawing ☐ pressure ☐ prickling ☐ radiating ☐ sharp ☐ soreness ☐ spasm ☐ stabbing ☐ throbbing ☐ tightness ☐ tingling ☐ other ____________________

Chronic Pain Duration____

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Body Measurements/Pain (chronic pain continued)

(only answer if yes to chronic pain above)

Factors that Aggravate Pain ☐ activity ☐ breathing ☐ eating ☐ not eating ☐ environmental ☐ family not present ☐ fear ☐ ineffective pain medication ☐ inactivity ☐ movement ☐ palpation ☐ positioning ☐ stimulation ☐ other

Factors that Relieve Chronic Pain ☐ acupuncture ☐ chiropractic ☐ cold ☐ distraction ☐ environment adjustment ☐ exercises ☐ heat ☐ imagery ☐ immobilization ☐ massage ☐ medication ☐ meditation ☐ music ☐ relaxation ☐ repositioning ☐ rest ☐ splinting ☐ transcutaneous electric nerve stimulator ☐ other _____

Roles/Relationships

Where does the patient live? ☐ family home ☐ foster home ☐ long-term care facility ☐ other _____

Lives With ☐ mother ☐ father ☐ mother and partner ☐ father and partner ☐ stepmother ☐ stepfather ☐ grandmother ☐ grandfather ☐ aunt ☐ uncle ☐ sister ☐ brother ☐ host family ☐ foster family ☐ legal guardian ☐ other _____

For patients under 12 months (365 days), where does your baby sleep at home? ☐ crib ☐ bassinet pack and play ☐ couch ☐ chair ☐ other (specify) _____

Do you have a crib or a pack and play for your baby to sleep in? ☐ Yes ☐ No (If no, please contact Social Work)

Primary Caregiver ☐ mother ☐ father ☐ grandmother ☐ grandfather ☐ aunt ☐ uncle ☐ sister ☐ brother ☐ host family ☐ foster family ☐ legal guardian ☐ other _____

Who has legal custody of the patient? ☐ parents ☐ mother ☐ father ☐ grandparent(s) ☐ aunt ☐ uncle ☐ foster family ☐ DHR (notify Social Services) Specify Name of Legal Custodian _____

Court Ordered Visitation? Yes/No **If Yes, copy on Chart?** Yes/No Visitation schedule _____

Limitations on Visitors/Phone Calls ☐ none ☐ immediate family may visit ☐ spouse may visit ☐ significant other/partner may visit ☐ no visitors ☐ no phone calls ☐ no release of information ☐ other _____

Patient/Primary Caregiver would like a support person to be notified of patient admission ☐ no ☐ yes

Does the patient have a DHR caseworker? Yes/No **If Yes, notify social services.**
If Yes, specify the name and county _____

Health and Illness

Reason for your Admission as Stated by Patient/Parent/Caregiver _____

Primary Care Physician _____ **Specialty Physician/Others** _____

Legal Guardian requests to opt out of primary care physician notifications? ☐ no ☐ yes

Case Manager/Sponsor _____

Services Anticipated at Discharge ☐ none ☐ specialized car seat (notify Patient Health and Safety/COA House Officer for car seat fitting) ☐ education services ☐ extended care facility ☐ home health care ☐ hospice care ☐ inpatient rehabilitation facility ☐ mental health services ☐ outpatient hemodialysis ☐ outpatient peritoneal dialysis ☐ outpatient rehabilitation ☐ skilled nursing facility ☐ support groups ☐ other _____

Anticipated Discharge Disposition ☐ home ☐ home with assist ☐ home with home health ☐ home with hospice ☐ home with outpatient services ☐ extended care facility ☐ foster/protective services ☐ inpatient hospice ☐ inpatient rehabilitation facility ☐ shelter ☐ street ☐ other _____

Person Authorized to Receive Patient on Discharge _____

Patient Aware of Diagnosis ☐ yes ☐ no ☐ not applicable secondary to age/developmental level _____

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Immunization History

Are Immunizations Up to Date? ☐ yes ☐ no **Verified by:** ☐ mother ☐ father ☐ grandparent ☐ caregiver ☐ foster parent ☐ medical record ☐ other ________________

Recent exposure ☐ none ☐ exposure to chicken pox within last month ☐ exposure to measles within last month ☐ exposure to mumps within last month ☐ exposure to TB within last 3 months ☐ exposure to pertussis within last month ☐ other ______________________

Present on Admission

Vascular Access Device ☐ yes ☐ no **Side location** ☐ left ☐ right ☐ bilateral **Insertion Date** _______________
Type ☐ CVL ☐ chronic dialysis catheter ☐ implanted port ☐ midline catheter ☐ PIV ☐ PICC

Urinary Device ☐ none ☐ indwelling urethral catheter ☐ suprapubic catheter ☐ urinary diversion ☐ intermittent catheterization ☐ Insertion Date/Last Catheterization Time ____

Pressure Injury(s) on Admission ☐ yes ☐ no **Number of Pressure Injury(s)/Location** _______________________
(Remember to document Plan of Care and page WOCRN)

Special Needs

Does the patient have a cognitive impairment? ☐ yes ☐ no **If yes,** ☐ difficulty remembering ☐ difficulty concentrating ☐ difficulty making decisions ☐ developmental delay

Visual Impairment? ☐ yes ☐ no **If yes,** ☐ blindness, left eye ☐ blindness, right eye ☐ serious difficulty, left eye ☐ serious difficulty, right eye **Patient relies on the following visual devices:** ☐ glasses ☐ contacts ☐ other ______

Hearing impairment? ☐ yes ☐ no **If yes,** ☐ deafness, left ear ☐ deafness, right ear ☐ serious difficulty, left ear ☐ serious difficulty, right ear **Patient relies on the following for hearing:** ☐ hearing aid ☐ sign language ☐ lip reading ☐ cochlear implants ☐ other ______________________________

Does the patient have a current medical condition that places them at risk and causes problems with mobility? ☐ yes ☐ no **If yes,** ☐ difficulty walking ☐ difficulty climbing up stairs ☐ difficulty climbing down stairs **Patient relies on the following equipment** ☐ wheelchair ☐ walker ☐ crutches ☐ cane ☐ other ____________________________

Does the patient have current medical condition/diagnosed condition that places them at risk for difficulty eating, playing, using hands, and or self care? ☐ yes ☐ no **If yes,** ☐ difficulty bathing ☐ difficulty dressing ☐ difficulty running errands alone

Is patient currently having difficulty with speech, communicating, or with swallowing? ☐ yes ☐ no
If yes, as evidenced by ☐ observation ☐ parent report ☐ risk due to condition

Patient currently using home medical equipment? ☐ yes ☐ no **If yes,** ☐ oxygen ☐ feeding pump ☐ infusion pump ☐ apnea monitor ☐ nebulizer ☐ ventilator ☐ other ____________________________________

General Medication Information

Medication Patch/Pump ☐ none ☐ medication patch(es) used (specify) ______________________________________
☐ medication pump(s) used (specify) ____

Anything Interfering with Ability to Follow Medication Schedule ☐ none ☐ age ☐ inability to prepare and administer dose correctly ☐ lack of knowledge regarding managing health concern ☐ lack of knowledge regarding medication purpose ☐ medication side effects ☐ unable to afford medications ☐ other __________________________

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General Medication Information (continued)

Herbal Remedies ☐ yes ☐ no **If yes,** ☐ echinacea ☐ fever few ☐ garlic ☐ ginger ☐ ginkgo ☐ goldenseal ☐ kava-kava ☐ licorice ☐ ma-huang (ephedra) ☐ saw palmetto ☐ St. John's Wart ☐ valerian ☐ other _____

Important Medication Experience/Information/Administration Techniques ☐ no concerns ☐ administer in food ☐ crush pills for administration ☐ cut pills in half ☐ difficulty swallowing pills ☐ requires elixir form ☐ other _____

Current Medications ☐ none ☐ unable to obtain _____

Current Medication (When EHR is available, enter current medications in Outpatient Medication Review)	**Dose**	**Frequency**	**Last dose taken**

Allergies/Intolerances (When EHR is available, ensure Allergies have been entered)

Allergies/Intolerances ☐ none ☐ unable to obtain _____

Allergies/Intolerances	**Reaction**

Previous Hospitalizations and Surgeries

Previous hospitalizations/surgeries? ☐ yes ☐ no
If yes, *Year/Reason_____

*Year/Reason_____

*Year/Reason_____

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Family History

____

____

____

Risk Screens

Columbia-Suicide Severity Scale (displayed for greater than 5 years of age) (Questions relate to past month)
Does this patient have a primary complaint that is emotional or behavioral in nature? ☐ yes ☐ no (stop)
If yes, ask questions 1 and 2

1. **Have you wished you were dead or wished you could go to sleep and not wake up?**
   ☐ yes ☐ no (continue below) ☐ unable to assess, Reason ________________________
2. **Have you actually had any thoughts of killing yourself?**
   ☐ yes (ask questions 3-6) ☐ no (continue to question 6)

If yes to questions 1 or 2, the patient is identified to be at high risk for suicide. Begin 1:1 observation and notify LIP

3. **Have you been thinking about how you might kill yourself?** ☐ yes ☐ no

If yes to question 3, the patient is identified to be at high risk for suicide. Begin 1:1 observation and notify LIP

4. **Have you had these thoughts and had some intention of acting on them?** ☐ yes ☐ no
5. **Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?** ☐ yes ☐ no
6. **Have you done anything, started or prepared to do anything to end your life? (past 3 months)** ☐ yes ☐ no

Sensory Risk
Does the patient meet sensory alert? ☐ yes ☐ no ☐ unable to assess
If unable to assess, Why can Sensory Alert Not be assessed? ☐ medically unstable ☐ trauma patient ☐ family not available ☐ unresponsive ☐ Other (please specify) _________________________

If Yes, Is your child sensitive/avoidant to the following: ☐ visual stimulation (lights, videos, etc) ☐ auditory stimulation (certain sounds, music, etc) ☐ smells ☐ touch/textures ☐ Other (please specify) ____________________________

If Yes, Does your child enjoy/seek stimulation from any of the following: ☐ visual stimulation (lights, videos, etc) ☐ auditory stimulation (certain sounds, music, etc) ☐ smells ☐ touch/textures ☐ Other (please specify) _____________

If Yes, How does your child prefer to communicate? ☐ verbal ☐ nonverbal ☐ communication device: ___________

If Yes, Your child learns best by: ☐ seeing (visual) ☐ hearing (auditory) ☐ touching and exploring (tactile) ☐ Other (please specify) ____________________________

If Yes, Specific triggers or things that may upset your child: ____

If Yes, Specific behaviors your child may exhibit when upset or becoming upset: _______________________________

If Yes, What helps your child calm down (comfort items, coping, techniques, etc)? ______________________________

If Yes, Dominant Hand ☐ right ☐ left

Functional Age: (example: 8 years old but functions on a 2 year old's level) ___________________________________

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Clinical Nutrition

Patient is on an altered feeding regimen, specialized formula, modified diet, food allergies, tube-feedings or TPN at home ☐ yes ☐ no **If yes, specify and notify nutrition services** ____

Patient diagnosed with chronic illness having nutritional impact ☐ yes ☐ no
If yes, specify and notify nutrition services ____

Is patient taking Warfarin/Coumadin at home? ☐ yes ☐ no **If yes, notify nutrition services** _________________

Ethnic/Religious Diet Preferences? ☐ yes ☐ no **If yes, notify nutrition services** ☐ Kosher ☐ strict Kosher
☐ no pork ☐ no beef ☐ no caffeine ☐ no shellfish ☐ other

Lactation

Is the patient lactating? ☐ yes (notify lactation services) ☐ no

Is the patient fed with breast milk? ☐ yes ☐ no

Is the mother lactating for patient/siblings? ☐ yes (offer/order pump equipment) ☐ no

Patient's mother has lactation concerns? ☐ yes (notify lactation services) ☐ no

Values/Beliefs/Practices (FICA)

F) Faith: What cultural, spiritual, or religious beliefs/practices are important for us to know?

____

I) Influence: How will these beliefs/practices influence your health care decisions?

____

C) Community: Are you part of a cultural, spiritual, or religious community/and is it supportive?

____

A) Address: How would you like for the health care team to address these values/beliefs/practices?

____

Substance Exposure/Use

Does your child have any caretakers who smoke cigarettes? ☐ yes ☐ no **If yes,** ☐ family member who lives with patient (specify) ☐ family member who does not live with patient (specify) ☐ friend or other caretaker (specify) ________
If yes, How often is your child with caretakers who smoke cigarettes? ☐ daily ☐ 2-4 times per week ☐ 4 or more times per week ☐ 2-3 times per month ☐ monthly or less ____

Do you allow smoking inside of your house or car? ☐ yes ☐ no ☐ n/a ________________________________

Patient's Smoking Status ☐ never smoker ☐ unknown if ever smoked ☐ *smoker, current status unknown
☐ *former smoker ☐ *current every day smoker ☐ *current some day smoker ☐ *light tobacco smoker ☐ *heavy tobacco smoker * smoking start date ______________________ * smoking end date _________________________

Is smoker, type of tobacco ☐ cigarettes ☐ cigars ☐ pipe ☐ hookah tobacco ☐ e-cigarettes
Previous treatment ☐ yes ☐ no **Smoking Cessation Program Interest** ☐ yes ☐ no **Instructed on no smoking policy** ☐ yes ☐ no

Patient's Chewing Tobacco Use ☐ never ☐ current ☐ past **If current/past,** ☐ occasional use ☐ 1-2 tins/week
☐ 2-4 tins/week ☐ 5 or more tins/week **Attempts to Quit Tobacco Use,** ☐ none ☐ antidepressant ☐ counseling
☐ hypnosis ☐ nicotine replacement therapy ☐ quit on own ☐ tobacco cessation program

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Substance Exposure/Use

Patient's Alcohol Use ☐ never ☐ current ☐ past **If current/past, alcohol last use** _____
If current/past, Alcohol Amount ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks _____
Alcohol Frequency ☐ monthly or less ☐ 2-4 times/month ☐ 2-3 times/wee ☐ 4 or more times/week ☐ daily
Alcohol Type ☐ beer ☐ wine ☐ liquor **Use duration** _____ **Readiness to Quit** ☐ not motivated to quit ☐ thinking about quitting ☐ ready to quit ☐ refuses to discuss **Attempts to Quit Alcohol** ☐ none ☐ Alcoholics Anonymous ☐ counseling ☐ detox unit ☐ outpatient treatment ☐ quit on own ☐ residential treatment ☐ support group **Method of Quitting** ☐ not motivated to quit ☐ thinking about quitting ☐ ready to quit ☐ refuses to discuss

Patient's Street Drug/Inhalent/Medication Use ☐ street drug/inhalents/medication never used ☐ street drug/inhalant/medication abuse current ☐ street drug/inhalant/medication abuse past
If current/past, Type ☐ amphetamines ☐ cocaine ☐ depressants ☐ ecstasy ☐ hallucinogens ☐ heroin ☐ inhalents (solvents, gases, nitrites, aerosols) ☐ marijuana ☐ mescaline ☐ methamphetamine ☐ narcotics ☐ PCP (phencyclidine) ☐ sedatives ☐ steroids ☐ stimulants _____
Route ☐ intravenous ☐ oral ☐ smoking ☐ snorting _____
Duration _____ **Quantity Consumed** ☐ unknown ☐ amount (specify) _____

Psychiatric History (Psychiatric Patients Only)

Responsible relative/guardian _____

Patient Search ☐ no ☐ yes (if yes, by whom?) _____

Patient has been oriented to ☐ room ☐ visiting policy ☐ inappropriate/appropriate items for patients ☐ meal times ☐ bed times ☐ patient rights ☐ use of restraint and seclusion

Family has been oriented to ☐ room ☐ visiting policy ☐ inappropriate/appropriate items for patients ☐ meal times ☐ bed times ☐ patient rights ☐ use of restraint and seclusion

Details of Current Problem _____
_____
_____
_____
_____
_____

Previous inpatient treatment ☐ none ☐ yes
If yes, *Year/Reason_____

*Year/Reason_____

*Year/Reason_____

*Year/Reason_____

Prior inpatient comments _____

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Psychiatric History (Psychiatric Patients Only)

Previous outpatient treatment ☐ none ☐ yes
If yes, *Year/Reason_____

*Year/Reason_____

*Year/Reason_____

*Year/Reason_____

Prior outpatient comments_____

Any contraindications in use of restraint? ☐ no ☐ yes (if yes, specify) _____

Other alternatives prior to restraint/seclusion? ☐ no ☐ yes (if yes, specify) _____

Is there a history of Electro Convulsive Therapy (ECT)? ☐ no ☐ yes (if yes, specify) _____

Is there a history of eating disorder? ☐ no ☐ anorexia ☐ binging ☐ purging ☐ laxative dependent ☐ other ____

Is there a history of excessive exercise? ☐ no ☐ yes (if yes, specify frequency) _____

Assist Devices ☐ contacts ☐ glasses ☐ hearing aids ☐ walker ☐ wheelchair ☐ prosthesis ☐ mouth guard ☐ retainer ☐ other (specify) _____

Elimination pattern ☐ normal ☐ incontinence ☐ enuresis ☐ diarrhea ☐ constipation ☐ encopresis ☐ other ____

Sleep difficulty ☐ no ☐ yes **Bedtime** _____ **Time Awakens** _____

Child was born ☐ full term ☐ late ☐ early (specify how early) _____

Age at which patient was able to say words _____

Is the patient unable to follow commands or to express him/herself as well as expected for age? ☐ no ☐ yes (specify)_____

Do you own any weapons? ☐ yes ☐ no **If yes, are firearms in locked area?** ☐ yes ☐ no

Family Psychiatric History _____

_____

_____

Family Medical History _____

_____

_____