Children's Health Ireland at Crumlin

HAEM-ONCOLOGY DAY UNIT NURSING ASSESSMENT

Full Name: ……………………………………

Address: ……………………………………

……………………………………………

HCR………………………………………

PATIENT DETAILS

Consultant:	Ward:	HcRN:
Patient Name:	Date of Birth:	Gender:
Patient Address:		
Language Spoken:	Interpreter Required: Yes ☐ No ☐	

NEXT OF KIN

Next of Kin (1)	*Next of Kin (2)*
Name:	Name:
Address:	Address:
Relationship to child:	Relationship to child:
Mobile No:	Mobile No:

GP	PUBLIC HEALTH NURSE
Name:	Health Centre Name:
Address:	Contact Name:
	Address:
Phone No: Fax No:	Phone No: Fax No:

Reason for Admission	*Isolation*		*Weight*	*Height*	*Date*	*Nurse Name*	*PEWS score*
	Yes	*No*					

VACCINATIONS

Upto Date: ☐ None ☐ Unknown ☐ *Give details*

Covid 19 Vaccinated: Yes ☐ No ☐ 1st dose given: Yes ☐ No ☐ Date: 2nd dose given ☐ No ☐ Date:

Type of Covid Vaccine given:

SURGICAL / MEDICAL HISTORY

CURRENT MEDICATION

ALLERGIES – *as per person accompanying child*

Medication, Tape / Plasters, Food, Lotions, Latex, other - Please give details:

Information Obtained from *(print name)*: …………………………… **Date:**…………… **Time:** ……………

Nursing Students Name *(print name)*: …………………………… **NMBI:** ……………

Registered Nurse Name *(print name)*:…………………………… **Grade:**…………… **NMBI:**……………

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Full Name: ....
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....
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INFECTIOUS DISEASES

Is the child known to be colonised with resistant organisms e.g. MRSA, ESBL, VRE, CRE: Yes □ No □

Transfer from other hospital: Yes □ No □ Attended a hospital abroad or known CRE hospital: Yes □ No □

Date												
Contact with Infectious Diseases in last Contact with Infectious Diseases in last 4 weeks 4 weeks	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Covid												
Measles												
Mumps												
Rubella												
Pertussis												
Chickenpox												
Gastroenteritis												
Any vomiting / diarrhoea in the last 72 hours												
Sign												

DISCHARGE

	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Observations in normal range												
Nutritional needs												
Pain control												
Prescription/Protocol given												
IV/CVAD care given												
Wound check												
Return date												
Discharge/Transfer time												
Other detail required												
Sign												

Safety Needs:

Type of IV Access: Peripheral □ Central □ Broviac □

Hair infestation / Pressure areas / Rashes / Bruising / Other:

Breathing and Circulation:

Controlling Body Temperature:

Rest and Sleep:

Mobility and Posture:

Eating and Drinking:

Play and Education:

Elimination: Urinalysis Date:

Expressing sexuality:

ID Band: Yes □ No □

Other

COMMENTS

Information Obtained from *(print name)*: .... **Date:**.............................. **Time:** ....

Nursing Students Name *(print name)*: .... **NMBI:** ....

Registered Nurse Name *(print name)*:...**Grade:**............................ **NMBI:**................