Sláinte Leanaí Éireann ag Cromghlinn
CHI
Children's Health Ireland at Crumlin

Medical Day Unit Nursing Assessment

Full Name: ....
Address: Addressograph
....
HCR..

PATIENT DETAILS	
Consultant:	HcRN:
Patient name:	Preferred name:
Date of birth:	Gender:
Language Spoken:	Translator Required: Yes ◻ No ◻
NEXT OF KIN DETAILS	
Name:	Relationship to child:
Address:	
Home phone no:	Mobile phone No:
Do parents understand the reason for admission: Yes ◻ No ◻	
GP	
Name:	
Address:	
Phone No:	Fax No:
VACCINATIONS *upto date* ◻	
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:	

MEDICATIONS ON ADMISSION	PREVIOUS MEDICAL / SURGICAL HISTORY

Safety Needs:
IV Access:
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:
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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Medical Day Unit
Nursing Assessment

Full Name:
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Address: Addressograph
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Reason for Admission	Date	Time *24hr clock*	Height	Weight	Nurse Name	NMBI

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 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***	***N/A***	***Yes***	***No***	***N/A***	***Yes***	***No***	***N/A***	***Yes***	***No***	***N/A***	***Yes***	***No***	***N/A***	***Yes***	***No***	***N/A***
Obs in normal range																		
Script given																		
IV / CVAD care given																		
Return Date																		
Discharge Date																		
Sign																		

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

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

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