Sláinte Leanaí Éireann
CHI
Children's Health Ireland

Nursing Assessment

Surgical Day Unit

Please use Special Needs Assessment Sheet 2, if indicated

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

PATIENT DETAILS

Ward:

Gender: Male □ Female □ Other □ **Height:** **Weight:**

Menstruating: Yes □ No □ LMP / Date: **HCG:** Yes □ No □ **HCG:** Positive □ Negative □

Language Spoken: | **Translator Required:** Yes □ No □

NEXT OF KIND DETAILS	GP
Next of Kin Sticker *Relationship to child:* *Mobile phone No:* *Home phone no:*	*GP Sticker*

Do parents understand the reason for admission: Yes □ No □

INFECTIOUS DISEASES

Contact with Infectious Diseases in last 4 weeks: *Covid, Measles, Mumps, Rubella, Pertussis, Chickenpox, Gastroenteritis, other*

Yes □ No □ *Give details*:...

In the last 72 hours, has the child: Vomited: Yes □ No □ Had Diarrhoea: Yes □ No □

Give details: ....

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 □

Give details: ....

Needs isolation: Yes □ No □ *Give details:* ....

Covid Swab done: Yes □ No □ Covid Precaution: Yes □ No □ Covid Result: Negative □ Positive □ N/A □

Additional information: ....

***** PEWS Score: Date: Time: *****

Medications on Admission	Previous Medical / Surgical History

Reason for Admission	Date	Time	Print Name	NMBI

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Maintaining a safe environment	Personal Cleansing & Dressing
Safety Needs:	*Hair infestation / Pressure areas / Rashes / Bruising / Other*
IV access: Yes □ No □ N/A □	
Consent signed: Yes □ No □	
Mobility & Posture	**Breathing & Circulation**
Eating & Drinking	**Controlling Body Temperature**
Rest & Sleep	**Elimination**

VACCINATIONS *upto date* □

None □ Unknown □ *Give details:* ....

Covid 19 Vaccinated: Yes □ No □ **1st dose given:** Yes □ No □ **2nd dose given:** Yes □ No □ **Booster:** Yes □ No □

Additional Information

Return to ward: **Time:**

	Anaesthetic criteria achieved	Doctor spoke to parents / child	Prescription Given	IV Cannula Removed	Wound Checked	Awake & Alert	Analgesia satisfactory	Eating & Drinking	Obs within normal range
Yes									
No									
N/A									

Discharge Date: **Discharge Time:**

OPD / PPC / GP / Dressing Clinic – Insert Date:

Information Obtained from *(print name)*: .... **Date**:.................... **Time**: ....
Nursing Students Name *(print name)*: .... **NMBI:** ....
Registered Nurse Name *(print name)*:.. **Grade**:.................... **NMBI**:....................