Acute Care - *Peds*

Your Practice Name **(000) 000-0000**

Your Street Address City ST 00000-0000

Patient's Name _____ DoB _____ Date _____ Seen with: ☐ Mth ☐ Fth ☐ Other_____ Chart # _____

History ☐ Regular Visit ☐ Follow-up Visit ☐ After Hours

Chief Complaint ☐ Pain 1 2 3 4 5 6 7 8 9 10

_____

_____

HPI _____

_____

_____

_____

Present Meds _____

_____

Drug Allergies ☐ Yes ☐ No _____

_____

Injury Date and time of injury_____ Location on body_____

Date of last tetanus _____

_____

Review of Systems (Necessary for Detailed / Comp. eval.)

☒ if positive ☑ if negative *Describe abnormalities*

☐ Constitutional	☐ Gastrointestinal	☐ Psychiatric
☐ Eyes	☐ Genitourinary	☐ Endocrine
☐ ENMT	☐ Musculoskeletal	☐ Hemat. / Lymph
☐ Cardiovascular	☐ Integumentary	☐ Allergic / Immun.
☐ Respiratory	☐ Neurological _____	

_____

_____

_____

Past / Social / Family History (Necessary for Detailed / Comp. eval.)

_____

_____

_____

_____

Hx reviewed by:

Physical Exam ☑ Nl ☒ Abn *Circle and describe abnormalities*

Wt_____ Ht_____ T_____ P_____ R_____ BP_____/_____

☐ Gen. Appear. looks ill 1+, 2+, 3+_____

☐ Head/Face/Neck appearance, swelling, defects_____

☐ Eyes red, swollen, drainage (clear, pur) _____

☐ Ears ☐ ext cerumen, swollen, tender, pur. _____

☐ R tm red, dull, thick, ↓ mobility, fluid, retract, bulging, perf., scarred, tube (in, out) _____

☐ L tm red, dull, thick, mobility, fluid (clear, pur.), retract, bulging, perf., scarred, (in _____

_____

☐ Nose /Sinuses cong, drainage (watery, mu, pur.), tender _____

☐ Mouth/Throat ulcers, drainage (mucoid, pur), injected _____

☐ Tonsils enlarged 0, 1+, 2+, 3+ 4+, exudate, petechiae _____

_____

☐ Respiratory rhonchi, wheezes, rales, ↓ br. sounds, retraction_____

☐ R ☐ L resp. distress 0, 1+, 2+, 3+ _____

_____

☐ Cardiovascular murmur, abn. rate / rhythm, SOB, cyanosis _____

_____

☐ Chest /Breasts swelling, tender, masses, defects_____

☐ Hem / Lymph petechiae, bruises, enlarged nodes _____

☐ Abd / Gastro distended, ↓ or ↑ peristalsis, tender, masses, hernia, enl. liver / spleen _____

_____

☐ GU / Genitalia abn. ext genitalia, swelling, tenderness, discharge _____

☐ Skin rashes, jaundice, birthmarks, abn. hair / nails _____

_____

☐ Back / Mus-Skel tenderness, swelling, weakness _____

_____

☐ Neuro / Psych _____

Procedures ☐ Consults, lab / x-rays, special studies, reports reviewed

Imm. Current? ☐ CBC _____ ☐ Pk Flow _____

Yes No ☐ Urine _____ ☐ Pulse Ox _____

☐ Quick Strep_____ ☐ Special studies_____

_____

_____

Impression / Abnormalities

_____

_____

_____

_____

_____

_____

_____

Plan / Treatment ☐ Referral

☐ Basic instructions given; parent seemed to understand

_____

_____

_____

_____

_____

Call: ☐ 24 Hrs. ☐ 48 Hrs., PRN ☐ Follow-up_____

Disposition: ☐ Home ☐ Referral ☐ Admitted

Condition: ☐ Unchanged ☐ Improved ☐ Stable ☐ Worse

Amount of time face to face (when using time based coding) _____

Provider Signature_____ Date _____

SAMPLE