PEDIATRIC HOME HEALTH CARE PLAN

Patient Identifiers:
Facial Recognition___
Patient Address_____

RECERT DATE

Demographics: **Payor Source:**_____

Client Name _____ Current Wgt. _____Ht._____

Address _____

_____

Phone _____

Primary Caregiver _____ Relationship _____

Pain Scale: 0---1----2----3----4----5----6----7----8----9-----10

Med Profile: Updated? Yes No Updated in home? Yes No Insurance card: Verified? Yes No Visual of card? Yes No

Medication Compliant? Yes No

Immunization schedule: (please circle)

HBV	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
DTaP	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
HiB	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
Poliomyelitis virus	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
MMR	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
Varicella	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
HAV	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
Streptococcus pneumonia	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
Influenza	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr
UTD	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	4-6 yr	11-12 yr	14-16 yr

Others living in household

Name _____ Age _____ Sex _____ Relationship _____

Name _____ Age _____ Sex _____ Relationship _____

Name _____ Age _____ Sex _____ Relationship _____

Name _____ Age _____ Sex _____ Relationship _____

#15. **Safety Measures:**

Ambulation with assistance/on stairs	yes	no	Complete/Partial asst. with ADL's	yes	no
Someone always in home	yes	no	Reality testing/orientation	yes	no
Blood/body fluid precautions	yes	no	Guards over steam heat/radiators	yes	no
Bathtub grab bars needed	yes	no	Any hanging table cloths	yes	no
Soiled Living Environment	yes	no	Hot objects out of reach	yes	no
Cluttered home/throw rugs	yes	no	Any loose clothing	yes	no
24 hour supervision	yes	no	Any accordion style gates used	yes	no
Oxygen precautions	yes	no	One household member CPR	yes	no
Seizure precautions	yes	no	Immunizations current	yes	no
Toxic substances out of reach	yes	no	Oxygen tanks secure & stable	yes	no
Fire extinguishers in home	yes	no	Adequate lighting on porch	yes	no
Oxygen "No Smoking" sign in place	yes	no	Any weapons in home	yes	no
Neighborhood appears safe	yes	no	If weapons, are they locked & unloaded	yes	no
Smoke detectors in home	yes	no	Any pets in home: type _____	yes	no
If smoke detectors, are detectors operational	yes	no	Car seat used	yes	no
Are there stairs in home	yes	no	Falls risk	yes	no
Telephone available / in reach	yes	no			

Safety instructions for staff caring for child_____

PEDIATRIC HOME HEALTH CARE PLAN

Community Support Assistance

In place_____/Referrals Needed_____

Cardiovascular Assessment **Temp: Ax** _____ **Rectal** _____

Apical _____ Radial _____ BP _____ Cap refill _____ Jugular Vein distension _____ Endurance _____

Consistently cold extremities _____ Diaphoresis _____ Clubbing _____ Cyanosis _____ Rhythm _____ reg irreg

Murmurs / abnormal sounds _____

Peripheral pulses _____ LDP _____ RDP _____ LPT _____ RPT _____

Edema _____ Location _____ 1+ _____ 2+ _____ 3+ _____ 4+ _____

Respiratory Assessment **Respiratory Rate** _____

Frequent URI _____ Dyspnea _____ at rest _____w / exertion _____ nocturnal _____

Home Treatments _____ Oxygen _____ Frequency _____ lpm _____ via _____ backup source _____

CPAP ____ PEEP ____ Ventilator _____ Suction _____ Catheter size _____ Suction to _____ Aerosols _____

Tracheostomy _____ Size _____ Type _____ Last Tube change _____ Changed by _____

Spare tube in home _____ Ambu bag _____ Trach ties _____ type _____

Lung Sounds: Clear _____ Wheezing _____ Inspiratory_____ Expiratory____ Fine Crackles _____ Rhonchi_____

Location _____Left _____ Right _____

Cough_____ Productive _____ Non-Productive _____ Unable to cough _____

Trach stoma: Appearance _____ Trach care _____ Secretions _____

Pulse ox _____ Frequency _____ Parameters _____ Actual reading _____ Probe placed _____

Comments _____

EENT Assessment

Vision: Blind ____ Right _____ Left _____ Vision limited _____ Diplopia_____ Glasses _____ ROP _____ Last eye exam _____

Comments _____

Hearing: Deaf ____ Right _____ Left _____ Impaired _____ Right_____ Left_____ Tinnitis _____ Hearing Aid _____ Right _____ Left _____

Ears__: _____ Drainage_____ Pain _____ Ear tubes present _____

Last hearing exam _____

Comments_____ _____

Nose: Patent ____ Right _____ Left _____ Secretions/Congestion _____

Mouth: Teeth _____ Gums _____ Lips _____ Dental Hygiene _____

Enlarged Lymph nodes _____ Location _____

Comments _____

_____

PEDIATRIC HOME HEALTH CARE PLAN

Musculoskeletal Assessment

Arthritis ____ Atrophy _____ Ataxia _____ Balance / gait unsteady_____ Cramps _____ Dislocations _____ Weakness _____

Deformities / contractures _____ ROM limitation _____ Joint Swelling _____ Joint pain _____ Joint crepitation _____ Joint stiffness _____

Mobility _____ Muscle strength _____ Muscle tone _____ Prosthesis _____ Paralysis _____ Amputation _____ Fx _____

Pain / weakness location _____ Deep tendon reflexes _____

Comments_____ _____

Gastrointestinal Assessment

Nausea _____ Vomiting _____ Projectile _____ Reflux_____ Spit ups _____ X per day; Colic _____ Diarrhea _____ X per day

Bowel Sounds _____ Ostomies _____ Constipation _____

Stools _____ X per day; Consistency _____ Color_____ Abdominal distention _____ Ascites_____ Anorexia_____ Indigestion _____

Hemoptysis_____ Flatulence _____ Swallowing difficulties _____ Abdominal circumference _____

Adaptive equipment for eating _____

Nutritional status: Appetite: Good _____ Fair _____ Poor _____ Weight : _____ Loss _____ Amt _____ Gain _____ Amt _____

Food allergies _____

Gastrostomy: Type _____ Size _____ Site appearance _____

Site care _____ Date last changed _____ Person doing changes _____

Tube Feedings: Amount _____ Frequency _____ Feeding type _____ Flush amount _____

Feeding pump _____ Type _____

Family participates in WIC _____ Food stamps _____ School meal plan _____ Day care program _____

Supplementary food needs: Type _____ Amount _____ Frequency _____

Nutritional intake: Juice _____ Amount _____ Frequency _____ Water _____ Amount _____ Frequency _____

Servings per day: Bread / carbo _____ Fruit _____ Dairy _____ Meat / protein _____

Special diet _____

Dietitian referral _____ Phone _____

Bowel Habits: Date last BM _____ Regimen _____ Frequency _____

Comments _____

_____

PEDIATRIC HOME HEALTH CARE PLAN

Genitourinary Assessment

Wets ____X per day Ostomy _____ Incontinent _____ Dysuria _____ Hematuria_____ Pain _____ Polyuria _____

Urine: Color _____ Odor _____ Sediment _____ Mucous _____

Toilet Training: _____/Assistance _____ Voids _____

Catheter: Suprapubic ____ Size ____ Change frequency_____; Foley _____ Size _____ Change frequency _____ Balloon Size _____

Date of last catheter change _____ Irrigation _____ Frequency _____ Solution _____

Intermittent Catherization _____ Size Catheter _____ Frequency _____

Ostomy: Type _____ ET tech / Nurse _____ Phone _____

Ostomy supplies from _____ Phone _____

Dialysis: Vascular access type _____ Bruit present _____ Frequency _____

Facility _____ Phone _____

Genitalia: Male Female Circumcision _____ Undescended testicle _____ Right _____ Left _____

Endocrine Assessment

IDDM _____ NIDDM _____ Polyuria _____ Polydipsia_____ Polyphagia _____ Juvenile onset _____ Age of Onset _____

Blood Sugar Testing: Frequency _____ Meter Type _____ Range _____

Person performing test _____ Insulin type _____ _____ Frequency _____

Dosage _____

Thyroid disease _____ Pituitary problems _____ Excessive bleeding / bruising _____ Heat / cold intolerance _____

Comments _____

Integumentary Assessment

Skin: Jaundice _____ Petechiae _____ Dry / cracked _____ Scars _____ Pruritis _____ Abrasions _____ Rash _____ Lesions _____

Ecchymosis _____ Cyanosis _____ Diaphoretic _____ Alopecia _____ Masses _____ Pallor _____

Pressure area _____ Poor skin turgor _____ Wound _____ Diaper rash _____ Milia _____ Edema _____ Incisions _____

Comments _____

Neurological Assessment

Refelxes: Moro ____ Startle _____ Parachute ____ Grasp ____ Rooting _____

Headaches: Insomnia _____ Pain _____ Numbness _____ Ataxia _____

Speech: Aphasia _____ Dysphagia _____ Receptive _____ Vertigo _____ Head Circumference _____ cm

Seizures: Type _____ Tremors____ Fine _____ Gross _____ Pupils _____

Anterior fontanel: Flat _____ Sunken _____ Bulging _____

Hand grip: Strong _____ Weak ____ Unequal _____ Gross motor changes _____ Fine motor changes _____

Pain: Intensity _____ Location _____ Pain quality: Burning _____ Dull ____ Intermittent ____ Constant ____ Cramping ____ Pins/needles ____

Comments _____

PEDIATRIC HOME HEALTH CARE PLAN

Infection Control Teaching_____

_____

Summary of care:

Source of data: Patient _____ Caregiver ____ MD _____ Other _____

Clinician Signature _____

Date _____ Time In _____ Time Out _____

INSURANCE VERIFICATION

INSURANCE INFORMATION: ID# _____

Insured Name _____ Insured SS# _____

Primary: ☐ Medicare ☐ Medicaid ☐ Private ☐ Waiver ☐ Passport ☐ Pvt Pay ☐ Workers' Comp ☐ UHHC ☐ Other _____

Policy # _____ Group # _____ Effect Date _____

Employer & Phone _____ ( ) _____ Insur Co. Name _____

Insur Co Phone _____ Mail to _____

Contact _____ Tx and # of Authorization _____

Deductible _____ Co-Pay Amt _____ Other _____

Secondary: ☐ Medicare ☐ Private ☐ Waiver ☐ Passport ☐ Pvt Pay ☐ Workers' Comp ☐ UHHC ☐ Other _____

Policy # _____ Group # _____ Effect Date _____