PEDIATRIC HOME HEALTH CARE PLAN

SOC DATE _____ /ROC DATE: _____

Demographics: **Patient Identifiers: Facial Recognition__Patient Address:__**
Payor Source:_____

Client Name _____ Date of Birth _____

Address _____ Birth Weight _____ Ht._____

_____ Current Wgt. _____Ht._____

Phone _____ Sex: M F Race: _____

Birth complications _____ Gestational Age _____

Religion _____ Church _____

Primary Language _____ Interpreter Needed ? Yes No

Physician _____ Phone_____

Date of last inpatient stay: From _____ to _____ Facility type _____

Primary Caregiver _____ Relationship _____

Directions to home _____

Emergency Contact _____ Relationship _____ Phone _____

Advance Directives: DNR orders _____ Resuscitate _____ POA_____ (if yes, complete following)

Name _____ Phone _____

#10. **Medications** – Use Medication Profile(s)

#11. **Principal Diagnosis** _____ Onset _____

#12. **Surgical Procedure** _____ Date _____

#13. **Other Diagnoses** _____ Date _____

#14. **DME and Supplies** _____

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 pneumoniae	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 _____

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#15. **Safety Measures:**

No ambulation without assistance	yes	no	Complete 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 heating appliances	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 extinguisher 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 batteries 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_____

Community Support Assistance

Assistance of persons other than home care agency (circle) relatives friends neighbors others in home paid help none

Other Community Agency Active _____

#16. **Nutritional Req.** _____

#17. **Allergies** _____

#18A. **Functional Limitations** ☐ Amputation ☐ Bowel / Bladder Incont ☐ Contracture ☐ Hearing ☐ Paralysis ☐ Endurance ☐ Ambulation ☐ Speech ☐ Legally blind ☐ Dyspnea with minimal exertion ☐ Other _____

#18B**. Activities Permitted** ☐ Complete Bedrest ☐ Bedrest BRP ☐ Up as tolerated ☐ Transfer bed / chair ☐ Exercises prescribed ☐ Partial weight bearing ☐ Indep at home ☐ Crutches ☐ Cane ☐ Wheelchair ☐ Walker ☐ No restrictions ☐ Other _____

#19. **Mental Status**	☐ Alert/oriented to	☐ Person	☐ Place	☐ Time	
	☐ Confused	☐ Forgetful	☐ Lethargic	☐ Inattentive	
	☐ Anxious	☐ Agitated	☐ Depressed	☐ Overwhelmed	☐ Poor judgment
	☐ Demanding	☐ Positive	☐ Motivated	☐ Non responsive	☐ Gaze aversion
Behavior	☐ Cooperative	☐ Disruptive	☐ Infantile	☐ Withdrawn	
	☐ Physical aggression	☐ Anxious	☐ Nervous	☐ Demanding	
#20. **Prognosis**	☐ Poor	☐ Guarded	☐ Fair	☐ Good	☐ Excellent

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+ _____

Defibrillator _____ Pacemaker _____ Rate _____ Last phone check _____ Last Battery check _____ Make / model _____

Cardio-respiratory Monitor _____ Settings _____ # alarms / 24 hours _____ Comments _____

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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: Vesicular _____ Wheezing _____ Inspiratory_____ Expiratory____ Cough _____ Productive _____ Non-productive _____

Unable to cough _____ Absent _____ Left _____ Right _____ fine crackles _____ Location _____

Rhonchi_____ Location _____

Trach stoma: Appearance _____ Trach care _____ Secretions _____

Chest physiotherapy: Frequency _____ Lobes _____ Time _____

Ventilator: Type _____ Model _____ Company _____ Phone _____

Settings: Tidal volume _____ Mode _____ BPM _____ Oxygen _____

CPAP ____ PEEP ____ PIP _____

Back Up vent available _____ Location _____ Battery hours available _____

Emergency protocol _____

Humidifier type _____Temp _____ Alarms: low _____ high _____Pressure Support _____ Apnea Interval _____

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

Ventilator upkeep: Circuit changes _____ HEPA filter change _____ Exhalation Valve _____ Humidifier changes _____

Respiratory therapist next visit _____ Name _____ Phone _____

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 _____

Last hearing exam _____

Comments_____ _____

Nose: Patent ____ Right _____ Left _____ Secretions _____

Mouth: Teeth _____ Gums _____ Lips _____ Dental Hygiene _____

Enlarged Lymph nodes _____ Location _____

Comments _____

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_____ _____

PEDIATRIC HOME HEALTH CARE PLAN

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 : Change _____ 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 _____

Ostomy _____ Reason _____ Location _____

Stoma appearance _____ Person doing care _____

ET tech / nurse _____ Phone _____

Ostomy Supply Company _____ Phone _____

Comments _____

_____

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 _____ Signature: _____ 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 _____

Menses irregular _____ Lesions _____ Genital drainage _____ Breast lumps _____ Breast Tenderness _____ Right _____ Left _____

Comments _____

PEDIATRIC HOME HEALTH CARE PLAN

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

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

Headaches: Insomnia _____ Pain _____ Numbness _____ Ataxia _____

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

Vocalizes _____Babbles _____ Speaks in phrases or sentences _____

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

Signs of Abuse

What happened _____

When _____ Where _____

Responsible person _____

Agency referral _____ Phone _____

Response to Illness _____

Caregiver response to client illness _____

Caregiver interaction with client _____

PEDIATRIC HOME HEALTH CARE PLAN

Financial Information

Current payment sources for home care_____

Financial Factors: Unable to afford medicine / supplies _____ Unable to afford medical expenses not covered by Insurance / Medicare _____

Unable to afford rent / utility bills _____ Unable to afford food _____ None _____

Comments _____

Social Environment

Are there any cultural aspects to be considered in care plan? Yes No

Are there any factors to be considered when behavioral plan is decided? Yes No

What are the house rules for the personnel caring for the child _____

_____

Comments _____ _____

Educational background of primary caregiver _____ Is patient caregiver ready to learn? Yes No

Is patient caregiver motivated to learn? Yes No Is the patient caregiver able to care for child without nursing personnel? Yes No

What are the learning needs of the primary caregiver? _____

_____

Leisure activities _____

Community agencies involved _____

Referrals needed _____

Sleep Patterns

Sleep problems _____

Bed time _____ Wake up time _____

Methods to get to sleep _____

Coping / Stress Tolerance

Coping Patterns _____

_____

_____

Self Perception: Expected _____

Actual _____

Affect _____

Growth & Development _____

PEDIATRIC HOME HEALTH CARE PLAN

Psychosocial

RISK FACTORS	Patient	Caregiver
Low birth weight (<2500gm)	☐	☐
Siblings	☐	☐
Daycare attendence	☐	☐
Exposure to smoke/other pollutants	☐	☐
Twin/Multiple birth	☐	☐
Family history of asthma	☐	☐
Distance from hospital care	☐	☐
Congential abnomalities of the airways	☐	☐
Neuromuscular disease	☐	☐
≥2 individuals sharing a bedroom	☐	☐
Crowed household	☐	☐
Anticipated cardiac surgery	☐	☐
Immundodeficiency	☐	☐

Homebound Status

☐ Non-ambulatory (child)	☐ Ambulatory (child)	☐ Ambulation difficult, unsafe	☐ SOB
☐ Weakness	☐ Dizziness	☐ Pain	☐ Gait unsteady
☐ Totally dependent	☐ Requires asst. to leave	☐ Personal	☐ Equipment
☐ Req port equip to leave	☐ TPN/IV	☐ O2	☐ Suction
☐ Ventilator	☐ Monitor	☐ Medically contraindicated to leave	☐ ↑ Risk Infection
☐ Immunosuppressed	☐ Hardship prevents leaving	☐ Other_____	

Assessment of family support _____

_____

Family expectations _____

_____

Infection Control Teaching_____

_____

_____

Additional Information needed to develop plan of care / teaching

_____

_____

_____

_____

_____

_____

_____

_____

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

Clinician Signature _____ Date _____

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 _____

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

Insur Co Phone _____ Mail to _____

Contact _____ Tx and # of Authorization _____

Deductible _____ Co-Pay Amt _____ Other _____