PROFESSIONAL NURSING SERVICE
PEDIATRIC NURSING VISIT REPORT

PATIENT IDENTIFIERS:
Facial Recognition ☐
Patient Address ☐
DOB initial visit ☐

Patient Name _____

Temp	Apical Pulse	Resp	Head Circ	B/P	Wt.	Ht.

NURSING ASSESSMENT OF SIGNS & SYMPTOMS

EMOTIONAL STATUS		NERVOUS		DIGESTIVE	
Lethargic		Grasp		Vomiting/Reflux	
Restless		LOC		GT Care	
Alert & Oriented		Reflexes		Type of Feeding	
Awake		Seizures		Frequency	
Sleeping Arousable		Tremors		Amount	
HEAD		PER RLA		Appetite (Good, Fair, Poor)	
Eyes		WOUND DRAINAGE		N & V	
Ears		Color		BS X 4	
Nose		Amount		Diarrhea	
Mouth		Consistency		Constipation	
Fontanels		Appearance		BM, Incontinence	
Shunt		RESPIRATORY		NG/Mickey	
MUSCULOSKELETAL		Dyspnea		Size	
WNL		Rales		Changed	
Hypotonia/Hypertonia		Rhonchi		ENVIRONMENTAL	
Flaccid		Wheeze		Safe Unsafe	
Crawls		Retractions		Activity	
Scoots		O2 Rate		Car Seat	
Lifts Head		Trach Size		Seat Belt	
Balance/Gait Unsteady		Trach Care		Mobility Hazards	
Weakness/Endurance		SOB		Fire Hazards	
Sits Supported		Clear to A/P auscultation		Universal Precautions	
Wheelchair		Suctioning		Side Rails Up	
Walker		Trach		GU/REPRODUCTIVE	
Exercises Prescribed		Oral		Urine	
Splints/AFO's		Nasal		Color	
MISCELLANEOUS		Postural Drainage		Odor	
Lab work		Apnea Monitor: alarms		Incontinence	
DME in use		Settings		Diapers	
Personal Care done		SKIN		Catheter	
Shower		Clammy			
Bath		Flushing		THERAPIES RECEIVING	
Oral Care		Jaundice		PT	
Meds given per med sheet		Pallor		OT	
IV THERAPY		Rash/itching		ST	
IV Location		Turgor		CARDIOVASCULAR	
PICC/Peripheral/Broviac		Chills		Arrhythmia/Regular	
Pump Setting		Warm/Dry/Cyanosis		Murmur/Gallop	
Med Port ☐ Accessed ☐ De-accessed		WOUND SIZE		Peripheral Pulses	
IV Dressing Changed ☐ Yes ☐ No		Length Width		Cap refill < 3 sec	
IV Dressing Intact ☐ Yes ☐ No		Depth		Cardiac Monitor: alarms	
Cap Change ☐ Yes ☐ No		Surrounding Tissue		Pulse Ox	
Tubing Change ☐ Yes ☐ No		SENSORY		Edema: describe	
Pump setting verified w/CG ☐ Yes ☐ No		Hearing			
Supply Inventory Checked ☐ Yes ☐ No		Sight			

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Parent/Guardian Signature _____ Date _____

Nurse Signature _____ Date _____ Time in _____ Time out _____

Patient's Name: _____

Date	Time	Medications	Nurse's Notes