

#P3 Injury or Fall (Pediatric)
 check box or (circle) word(s) if affirmative, -strike- word(s) if negative, note additional findings

Date: _____ Time: _____ Room: _____

Patient's Pediatrician and / or Specialists: _____ Vital Signs Reviewed

P: _____ **BP:** _____ **RR:** _____ **T:** _____ oral lb tympanic kg rectal **Wght:** _____

Allergies: NKDA see RN notes

Arrived by: EMS walk-in wheelchair

Historian: patient family / friend EMS

Chief Complaint: Injury Fall

History of Present Illness *Levels 1, 2, 3: 1-3 elements Levels 4, 5: 4 or more elements*

Onset: <input type="checkbox"/> unknown <input type="checkbox"/> today _____ <input type="checkbox"/> am <input type="checkbox"/> pm _____ <input type="checkbox"/> min. <input type="checkbox"/> hours <input type="checkbox"/> days P.T.A.	Description of Injury (Quality): <input type="checkbox"/> contusion / bruise <input type="checkbox"/> laceration <input type="checkbox"/> sprain / strain <input type="checkbox"/> abrasion <input type="checkbox"/> deformity / fracture <input type="checkbox"/> puncture <input type="checkbox"/> possible dislocation	Severity: At worst (0-10): _____ <input type="checkbox"/> mild <input type="checkbox"/> mod. <input type="checkbox"/> severe At present (0-10): _____ <input type="checkbox"/> mild <input type="checkbox"/> mod. <input type="checkbox"/> severe
Locale: <input type="checkbox"/> home <input type="checkbox"/> school <input type="checkbox"/> street <input type="checkbox"/> neighbor's <input type="checkbox"/> park <input type="checkbox"/> work	Location of Pain / Injuries: <input type="checkbox"/> head <input type="checkbox"/> abdomen <input type="checkbox"/> RUE <input type="checkbox"/> face <input type="checkbox"/> upper back <input type="checkbox"/> LUE <input type="checkbox"/> neck <input type="checkbox"/> lower back <input type="checkbox"/> RLE <input type="checkbox"/> chest <input type="checkbox"/> pelvis <input type="checkbox"/> LLE	Associated Symptoms: <input type="checkbox"/> none <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> difficulty breathing <input type="checkbox"/> difficulty bearing weight / walking
Mechanism of Injury: <input type="checkbox"/> unknown <input type="checkbox"/> struck by object <input type="checkbox"/> sports injury <input type="checkbox"/> MVC <input type="checkbox"/> altercation / "fight" <input type="checkbox"/> fall from: <input type="checkbox"/> standing position <input type="checkbox"/> chair / bed <input type="checkbox"/> _____ feet (height)		If Head Injury <input type="checkbox"/> no known head injury <input type="checkbox"/> immediate cry? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> loss of consciousness? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> decreased LOC since injury? <input type="checkbox"/> yes <input type="checkbox"/> no

Context: _____

Review of Systems *Levels 1, 2, 3: 1 system Level 4: 2-9 systems Level 5: 10 or more systems*

<input type="checkbox"/> All systems reviewed: <input type="checkbox"/> negative <input type="checkbox"/> negative except as marked below	<input type="checkbox"/> History limited / unobtainable due to: <input type="checkbox"/> altered LOC <input type="checkbox"/> patient acuity
Constit: <input type="checkbox"/> persistent crying <input type="checkbox"/> fever Eyes: <input type="checkbox"/> visual change <input type="checkbox"/> pain <input type="checkbox"/> redness ENT: <input type="checkbox"/> sore throat <input type="checkbox"/> ear pain <input type="checkbox"/> hearing loss CV: <input type="checkbox"/> chest discomfort <input type="checkbox"/> palpitations Resp: <input type="checkbox"/> difficulty breathing <input type="checkbox"/> wheezing <input type="checkbox"/> cough GI: <input type="checkbox"/> abdominal discomfort <input type="checkbox"/> diarrhea	GU: <input type="checkbox"/> urinary problems <input type="checkbox"/> hematuria <input type="checkbox"/> LMP: _____ Musc: <input type="checkbox"/> see History of Present Illness for Musc symptoms Neuro: <input type="checkbox"/> headache <input type="checkbox"/> neuro deficit <input type="checkbox"/> lethargic <input type="checkbox"/> fussy / irritable Skin: <input type="checkbox"/> rash <input type="checkbox"/> swelling <input type="checkbox"/> laceration / abrasion <input type="checkbox"/> bruising Psych: <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> hallucinations Immun: <input type="checkbox"/> HIV / AIDS

Past, Family, and Social History *Levels 1, 2, 3: no history areas Level 4: 1 history area Level 5: 2-3 history areas*

PMH: <input type="checkbox"/> none <input type="checkbox"/> unknown <input type="checkbox"/> see RN notes	Meds: <input type="checkbox"/> none <input type="checkbox"/> see RN notes Tetanus current: <input type="checkbox"/> yes <input type="checkbox"/> no	Surgical Hx: <input type="checkbox"/> none Family Hx: <input type="checkbox"/> none <input type="checkbox"/> hemophillia	Social Hx: <input type="checkbox"/> unknown <input type="checkbox"/> caretaker (other than parent) <input type="checkbox"/> daycare <input type="checkbox"/> school
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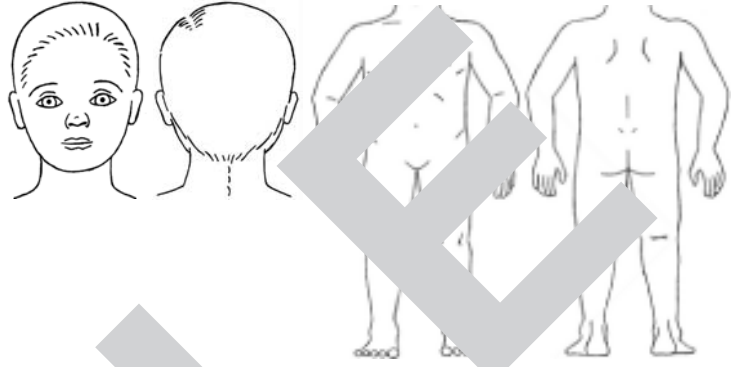
Physical Exam *Level 1: 1 organ system Levels 2, 3: 2-5 organ systems Level 4: 6-7 organ systems Level 5: 8 or more organ systems*

Gen: distress: <input type="checkbox"/> none <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe hydration: <input type="checkbox"/> nl <input type="checkbox"/> dehydrated nutrition: <input type="checkbox"/> nl <input type="checkbox"/> malnourished <input type="checkbox"/> alert, active <input type="checkbox"/> playful <input type="checkbox"/> smiling <input type="checkbox"/> attentiveness	Neck: <input type="checkbox"/> nontender <input type="checkbox"/> painless ROM <input type="checkbox"/> trachea midline CV: <input type="checkbox"/> regular rate, rhythm <input type="checkbox"/> heart sounds nl, no murmur <input type="checkbox"/> distal pulses strong and symmetric
Head: <input type="checkbox"/> no evidence of trauma <input type="checkbox"/> no Raccoon Eyes <input type="checkbox"/> no Battle's sign	Resp: <input type="checkbox"/> no resp. distress <input type="checkbox"/> breath sounds clear and equal <input type="checkbox"/> chest nontender
Eyes: <input type="checkbox"/> PERRL <input type="checkbox"/> EOMI <input type="checkbox"/> lids, sclera nl	Abd: <input type="checkbox"/> soft, nontender <input type="checkbox"/> no organomegaly <input type="checkbox"/> rectal nl, heme negative
ENT: <input type="checkbox"/> external facial exam nl <input type="checkbox"/> no hemotympanum <input type="checkbox"/> nasal exam nl	GU: male: <input type="checkbox"/> nl to inspection female: <input type="checkbox"/> nl to inspection

Physical Exam (continued)	<input type="checkbox"/> Exam limited by patient condition or acuity
Neuro: <input type="checkbox"/> alert and playful <input type="checkbox"/> motor nl as tested <input type="checkbox"/> reflexes nl <input type="checkbox"/> cranial nerves nl as tested <input type="checkbox"/> sensory intact to light touch <input type="checkbox"/> gait nl	
Psych: <input type="checkbox"/> affect, mood nl <input type="checkbox"/> nl attention, interaction	
Skin: <input type="checkbox"/> warm, dry <input type="checkbox"/> no rash <input type="checkbox"/> no cyanosis or pallor	

Musculoskeletal: back nl to inspection, nl to palpation

- RUE:** non-traumatic appearance
 non-tender to palpation
 nl range of motion
- LUE:** non-traumatic appearance
 non-tender to palpation
 nl range of motion
- RLE:** non-traumatic appearance
 non-tender to palpation
 nl range of motion
- LLE:** non-traumatic appearance
 non-tender to palpation
 nl range of motion



Medical Decision Making *Level 1: straightforward Levels 2-3: low complexity Level 4: moderate complexity Level 5: high complexity*

Differential Diagnosis contusion laceration / abrasion head injury / concussion chest trauma penetrating injury
 sprain / strain fracture dislocation / subluxation cervical injury abdominal trauma _____

Labs CBC: nl nl except values noted below: **Pulse Ox:** _____ % on RA or O₂: _____
WBC _____ Hb _____ Hct _____ Plt _____ Saturation is: normal hypoxic
neut _____ lymphs _____ other _____

Chem: nl nl except values noted below: **EKG:** rate: _____ rhythm: _____
Na _____ K _____ Cl _____ CO₂ _____ intervals: _____ ST/T-waves: _____
BUN _____ Cr _____ Glucose _____ other findings: _____

UA: nl RBCs _____ WBCs _____ dip _____

X-rays / Imaging interpreted by: me radiologist
(NAD=no acute disease) discussed w/ radiologist

1. _____ NAD 2. _____ NAD
3. _____ NAD 4. _____ NAD 5. _____ NAD

Treatment / Management / Course

- medication / treatment: response:
- O₂
 - IV fluids
 - tylenol
 - ibuprofen
 - wound care
 - sling
 - splint
 - crutches

Procedure: _____ see addendum
Critical Care: _____ min. see addendum
Reviewed: nurses notes EMS notes old records
Consultation: Dr. _____ (time) _____
Notes:

Wound Repair: sutures staples adhesive
Location: _____ Length: _____ cm
Depth: superficial subcut. intramuscular
Shape: linear irregular flap stellate
Contaminated: minimal moderate severe
 Neurovascular intact adjacent and distal to wound
Anesthesia: _____ cc of _____
(with: epi bicarb)
Explored: no tendon or nerve injury
 no F.B. F.B. found F.B. removed
 thoroughly cleansed and / or irrigated
Repair: _____ # of _____-O _____ sutures
_____ # of _____-O _____ sutures
 Multi-layer repair (skin subcut fascia)

Course: same better worse signed out to _____ (time) _____

Diagnosis 1. _____ 2. _____ 3. _____

Disposition Home Admit (medical surgical monitor ICU) Admit Physician: _____ Transfer to: _____
 Case and instructions discussed with, understood by, and agreed upon by: patient family caretaker
Follow up: PMD and/or other clinician _____ in _____ days or prn Written instructions provided

Condition: <input type="checkbox"/> unchanged <input type="checkbox"/> improved <input type="checkbox"/> stable	signature _____	title _____	date _____	time _____
<input type="checkbox"/> History confirmed in solo interview <input type="checkbox"/> Child Protective Services notified	signature _____	title _____	date _____	time _____

Discharge Prescriptions / Instructions: _____