In the Supreme Court of the State of Nevada

CLARK COUNTY SCHOOL DISTRICT,

Appellant,

v.

MAKANI KAI PAYO,

Respondent.

Supreme Court No. 68443

RESPONDENT'S APPENDIX VOLUME II

Robert O. Kurth, Jr.
Nevada Bar No. 4659
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Las Vegas, NV 89129
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Attorney for Respondent
MAKANI KAI PAYO

ALPHABETICAL INDEX

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 17th day of March, 2016, I served via electronic service and by placing a full, true and correct copy of the foregoing **RESPONDENT'S APPENDIX VOLUME II** in a sealed, first-class postage-prepaid envelope, in the U.S. Mail, and addressed to the following:

Daniel L. O'Brien
Office of the General Counsel
Clark County School District
5100 West Sahara Avenue
Las Vegas, NV 89146
Attorney for Appellant

/s/ Liberty Ringor
An employee of **KURTH LAW OFFICE**.

UMC
UNIVERSITY MEDICAL CENTER

260

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
FISHER, JAY D
MR# 001-191-358 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	PEDS H&P – MSIII
5/19/04	1415	1D M yo ♀
		– CC: HA's 2° occular trauma
		– HPI: 1 week ago, was struck head-on by a swinging hockey stick. There was residual LOC x 10sec. (sheriff) Impact broke glasses bleeding 2° laceration. The eye filled c blood N/V throughout night. Vision in periphery was obstructed and by the next day, his vision was blurred + blood covered the pupil; N/V persisted, HA on (L) temporal & parietal region of throbbing come + go every hour. 2 days later, he went to Quick Care and was transported to UMC Peds ER. Dr. Carr, Opthamalogist saw the pt. Rx'd some eyedrops & was D/C'd to F/U in optho office. Went to clinic on Saturday was given Trusopt drops (carbonic anhyorase inh) + Methazolamide orally. Sunday, N/V + HA persisted. On Monday, Dr. Carr examined again & was told he had blood clot and recc. to con't drops q 15 min. Came to ED today 2° ↑ occular pressure as Dx'd in Carr's clinic this AM.
Pain ↑ by: light ↓ by: calm, elevation, rest, dim lighting		
		– PMH: No other eye trauma or h/o trauma. Wears glasses x 3 yrs 2° near-sighted. Optometrist @ Galleria Ctr. Otherwise healthy
		– Fam Hx: DM – GPa ♀ + GMa ♂, Paternal c aneurysms
		+ Soc Hx: Lives c. mom, uncle, GMa + 3 sibs

Jayani Fisher

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
FISHER, JAY D
MR# 001-191-350 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
		SocHx: 6th grade, Honors student.
		No smoke @ home.
		BirthHx: FT, NSVD, Ø complications. 7#40z.
		Immun: all to date.
		Meds: Ø Allergies: Ø Surg: Ø.
Labs:		PE: V/S: T=98[4] HR=60 RR=20 BP=112/67
Ø		Wt: 35kg (50%)
		Gen: N.A.D.
		HEENT: 8OMI, PEARL on OD, OS accomodates,
		but pupil not appreciated 2° hyphema obstructing.
		Neck: ⊖JVD, trach midline.
		CV: Reg Rhythm Ø m, Bounding pulse.
		Lungs: CTA (B)
		Abd: S/NT/ND, BS present, ⊖organomegaly/masses
		Extrem: ⊕ pulses, ⊖c/c/e, skin cool to touch.
		ED course: Was given 2mg MSO4 I.V. + Zofran 4mg I
		Note [illegible]. Pt [illegible] & [illegible]
		[illegible] c̄ [illegible]
		[illegible] c̄ [illegible]
		Imp: [illegible] c̄ hyphema &
		2° acute angle glaucoma
		[signature]
		[signature] MS III

97-078

0 0190
RA 0078

![UMC University Medical Center]

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
		R1 admission
5/19/4		11 yr old ♂ c h/o of Ⓛ eye trauma 1 wk ago
		struck by Hockey stick → broke glass lens → Ⓛ eyelid
Ⓟ pain c light		blood @ white part of his eye → vomit / loss of peripheral
⊕ HA		vision progress to blurry vision. seen by Dr. Carr IOP 20 mmHg (13)
⊕ vomit		next day to 60 mmHg → and pt admitted.
Dr. Carr		PE: afebrile BP 112/67
840-2820		Ⓡ eye - normal
		Ⓛ eye - small lac. to lid
2020		- conjunct. hmg
231		- pupil not appreciated 2° to hyphema
		cloudy
		- EOM1 EOM
		- pain c light
		→ spoke to Dr. Carr plan OR - AM with pt consent
		NPO after Ⓜ Morphine / Zofran / Cosopt / Diamox
		Murphy
		[signature]

0 0191

RA 0079

97-078

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	Ophthalmology Note
5/19/04	1840	
T. CARRS		Makani sustained a hockey stick inj OS last week → traumatic hyphema - total (eight ball) with near normal intraocular pressure. However c clot formation + retraction he has developed an elevated IOP OS (from 26 → 52) associated N/V and intense Ⓓ eye pain and dehydration c malaise. A hospital admission is necessary to promote diuresis + infuse topical eye drops + IV fluids to prepare him for surgical evacuation w/n 48° hopefully by Fri 5/21/04.
	O	O/E V 20/20 T-16 L.P. Ø projection ↑ 52 Pupils - OD 3 mm RTL OS ? not seen Total hyphema OS c clot retraction Cornea of the OD "steamy" OS
	A	Traumatic hyphema OS - total Secondary Glaucoma OS c extreme IOP elevation c potential for blood stained cornea! Visual prognosis OS: Guarded

07 078

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PROGRESS NOTES

DATE	TIME	
5/19/04	P	Ophth continued - Topical Trusopt 2% 1 gtt OS BID Timolol 0.5% 1 gtt OS BID Diamox 125mg 1 VPB BID When IOP becomes ≈ 20 mm Hg will proceed to surgery for evacuation of hyphema Left eye. Check IOP daily

0 0193

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ACCT: 0075603365 DOD 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

PROGRESS NOTES

DATE 5/20/04	TIME	PEDS NOTE - MS III
Opth Carr	11:05	S: Pt resting comfortably this AM HA↓, N/V improved
		"I feel a lot." Pt amb to bathroom + voiding well TOL diet
Meds		O: V/S & Tc = 97.6 Tm = 100 HR = 55 RR = 19 BP = 108/59
- Timolol 0.5% drops OS x 1 BID		SaO2 = 99% R.A. Wt = 35kg (50%ile) I/O = 1860/1365 clears + sips
		Gen: N.A.D
- Trusopt 1gtt OS BID		HEENT: OS remains swollen c mild lacrimation
- D5½NS c 20 KCl @ 100cc/hr		CV: Reg Rhythm, ∅ m
- Diamox 125 BID		Lungs CTA (B)
		Abd: S/NT/ND, BS present, ∅ mass/megaly
		Extrem: 2+ pulses, ∅ c/c/e, cool to touch
		Labs = ∅
		A/P: 11 yo ♀ c traumatic glaucoma (↑ I.O.P)
		1) Cont eye drops + Diamox to ↓ I.O.P
		will consult c Carr for mg + poss surgery Fri
		2) CV/Pulm: Stable @ this time
		3) H/ID: None @ this time
		4) FEN/GI: Mntn IVF hydration, DAT
		Note read. Agree [signature]
		[signature] MS III

0 0194

97-078

RA 0082

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI E
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	MYC
5/20/04	(S)	∅ acute event overnight complains of HA overnight
	(O)	T 97 HR 56 RR 19 BC 108/65
		I/O 1860 / 1368
Med		Gen: Alert
① Timolol		[illegible]
② Cosopt		[illegible]
③ [illegible]		[illegible]
④ Diamox		[illegible]
	(A/P)	[illegible] Glaucoma [illegible]
		[illegible]
		[illegible] BC 108/69 [illegible]
		[illegible] ∅
		[illegible] IOP 62 [illegible]
		will wait [illegible]
		plan OR - Friday
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		To [illegible] CT scan
5-20-04	[illegible]	CT Brain [illegible]

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97-078

RA 0083

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PROGRESS NOTES

DATE	TIME	
5/20/04		By Nati
	S	- Feels much better little to no eye pain or discomfort OS
	O	- VA 10 hyphema remains total c VLP. Hyphema dissolution of lg clot OS. Tonopen OS - 25, 28, 33, 35
	A	- Responding favorably to Rx
	P	- To OR tomorrow a.m. for evacuation of hyphema under GA.

0 0196

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PROGRESS NOTES

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

DATE	TIME	
		PEDS NOTE - MSIII
5/21/04	6:35	S: Pt slept well last nt, still nauseous yest.
		Amb to Bathroom. H/A + eye pain ↓
meds		O: V/S $T^c = 97^8$ Tm = 99' HR = 65 RR = 18 BP = 112/56
		SaO_2 = 98-99% R.A. I/O's = 2780/1675
- Acetazolamide 125	BID	Only ate 10%/10%/30% meals yest.
- Trusopt 1gtt	BID	Gen: N.A.D. Resting comfortably.
- Timolol 1gtt	BID	HEENT: OS edema persists.
- D5 ½NS @100cc/hr		CV: Reg Rhythm, ø m
		Lungs: CTA Ⓑ
		Abd: S/NT/ND BS present, ⊖ masses/organomegaly.
		Extrem: 2⊕ pulses, ⊖ c/c/e.
		Labs: CT Brain = Ⓝ
		A/P: 11 y/o ♀ c̄ Ⓛ hyphema.
		1) OR today for evacuation - will F/U
		c̄ Dr. Carr for care.
		2) Mntn. IVF hydration
		3) Will monitor N/V for prn Zofran.
		Note [illegible]. [illegible]
		To Surgery today.
		[signature] [signature] MSIII

0 0197

RA 0085

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
		N, PN
5/21/4	(S)	Ø acute [illegible] [illegible] still have HA / [illegible]
	(O)	VS T 97.8 HR 66 RR 18 BP 112/66
		[illegible] 2380 / 1610
meds		Gen: [illegible] / [illegible]
① [illegible]		[illegible]: (L) [illegible]
② [illegible]		[illegible]: [illegible]
③ [illegible]		[illegible]: [illegible]
④ [illegible]		[illegible]: [illegible]
		[illegible]: [illegible]
	(A/P)	11 y/o ♂ c̄ (L) [illegible] [illegible] 2° [illegible] / [illegible]
		- OR today [illegible] pt [illegible] [illegible]
CT brain: [illegible]		[illegible] - (B) anticipate OR today - [illegible] / Dr. [illegible]
[illegible] : neg		[illegible]
		[illegible]
135 | 101 | 8 < 101 4.8 | 23 | 0.6		Pt [illegible]
		[illegible]
8.4 / 15.2 / 343		[illegible]
G 76%; L 16.3%		

0 0198

97-079

RA 0086

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

POST-PROCEDURE PROGRESS NOTE

I have discussed the operation and/or procedure with the patient/guardian, including reasonable expectations regarding a beneficial outcome and alternative treatments. We also discussed the general and necessary risks and complications of this operation/procedure and the possible need for and risk of blood or blood products and available alternatives. The patient has had all questions answered pertaining to this procedure. As a result, I believe that the patient understands the general necessary risks and potential benefits of this treatment and available alternatives, and agrees to services to be provided.

Signature of Physician: [signature] Date / Time: 5/21/04 10°°

This is an emergency procedure. Informed consent was not obtained.

Signature of Physician: Date / Time:

PREOP DIAGNOSIS: #22895 Traumatic Hyphema OS

POSTOP DIAGNOSIS: same

PROCEDURE: Evacuation of hyphema OS
Wash-out of vitreous chamber OS

Surgeon (Attending): T CARR

Participating Surgeon:

Assistant Surgeon:

Anesthesiologist: Yakits Anesthesia: General

Findings: total hyphema & clot OS
ad lentum to iris plane

Complications: 0

Estimated Blood Loss: 0

Specimens: 0

Drains: 0

Signature of Physician: [signature] Date / Time: 5/21/04 11:24

Form # 96-040

PROGRESS NOTES

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
		M post op note
5/21/4	2:30 pm	11 yr old ♂ ō (L) ocular Glaucoma 2° to traumatic hyphema
		(s/p evacuation) pod #0
		pt doing well post op. ∅ N/V. states that he feels better
		∅ sign post op c/o VS stable
		awake alert responsive CVS: S1S2 ∅R resp: CTA (B)
		continue same med.
		[signature]

0 0200

RA 0088

97-078

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ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
		R2 Note
5/22/04	0630	S: pain controlled ē MSO4 and Tylenol x1 O/N. tolerating sips.
		O: Tmax 99⁶ HR 63-84 RR 18-20 BP 90-112/50-69
I = 2240		Gen asleep, comfortable on RA. Eye patch in place
O = 1450		CV RR ∅M Lungs CTA(B) good air ∅ ↑ Resp Effort
U/O = 2.32		Abd soft NT ND ⊕BS ∅HSM Extr ∅c/c/e CR < 2 secs.
		Neuro nonfocal
meds		
pred forte		Labs: CT head - nL
atropine		A/P: 11 y/o M ē Ⓛ ocular trauma, Hyphema, ↑ ocular pressure
trusopt		now POD #1 s/p evacuation of hyphema; wash out of ant
timolol		chamber.
Tylenol		① FEN/GI: IVF-M. tolerating sips.
zofran		② CV/Resp: stable on RA, ∅ issues.
		③ Neuro: MSO4 and Tylenol x1. ∅ further pain O/N.
		④ Optho: Dr. Carr following. Eye patched following surgery.
		able to remove patch today and start meds - pred forte,
		atropine, trusopt, timolol then repatch.
		[signature]
		Nl Ortho. Pt. seen [illegible] Postop d1
		[illegible] Discussed ē [illegible]
		Plan [illegible]
		[signature]

0 0201

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ACCT: 0075603366 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
5/22/04	S	POD# Evacuation of hyphema OS
		— No pain
	O	— V
		V Hand Motion Tonopen 13, 11, 12
		Cornea — ? blood staining
		AC — lg flat fibrin / Hb clot
		over pupil
		No view of posterior pole
	A	— Improving medical regimen
	P	— Cont Eye drops + D
		metallic shield OS
		Home tomorrow if IOP NL range.

0 0202

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ACCT: 0075603365 DOD 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
5/23/04	S-	Eye Note POD#2 feels dizzy c N/V, no eye pain + vision remains down
	O-	VHM Tonopen 23, 18, 15, 13 (1) cornea c mild blood stain pupil 8mm dilation Hb clot remain across pupil Post segment = no view OS
	A-	Stable post op evacuation hyphema OS c normal IOP
	P-	Hold Atropine drops due to mild erythema skin OS OK for discharge eye-wise to follow up c Dr Can follow day, call to arrange appt Ast for out patient eye drops Pred forte 1% - 1gtt OS QID Timolol 0.5% - 1gtt OS BID Tobrex oint 1/8" OS BID Eye shield @ bedtime only Eye sen glasses otherwise - all times.

0 0203

07-078

RA 0091

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ACCT: 0075603365 DOB 09/22/1992
PAYO, HAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PROGRESS NOTES

DATE	TIME	
		MPP
5/23/04	S	∅ acute events overnight
	O	VS T 98.7 HR 69 RR 18 BP 116/68
		LA –
		GEN : asleep
		HEENT : Ⓛ [illegible] dry lip.
		[illegible] : CTA ∅ [illegible]
		[illegible] : RRR Ⓢ
		ABD : soft [illegible]
		EXT : good cap refill
	A/P	[illegible] Ⓛ [illegible] (s/p [illegible])
		FEN/GI – [illegible] not to [illegible]
		[illegible] – [illegible] stable on [illegible]
		[illegible] – ∅ issue
		[illegible] – spoke [illegible] possible d/c [illegible]
		[illegible signature]
		Note [illegible]: Pt. seen & [illegible] [illegible], pt OK for d/c [illegible]
		Discussed c staff
		[illegible signature]

University Medical Center of Southern Nevada

Department of Pathology

1800 West Charleston Blvd., Las Vegas, Nevada 89102

Carol van der Harten, M.D., Director of Laboratories

Patient Name :	PAYO, MAKANI K	Room :PEDS:0260-01	Print Date: 5/20/04
Hospital No. :	75603365	MRN : 1191358	DOB: 09/22/1992
Discharge Date :		Doctor: LAZERSON, JACK	Sex: Male

HEMATOLOGY

COMPLETE BLOOD COUNT

Date 05/20/2004
Day of Stay Thu
Time 14:25:00

Procedure		Units	Ref Range
WBC	8.40	K/MM3	[4.00-12.00]
RBC	5.43 H	M/MM3	[4.50-5.30]
HGB	15.2	G/DL	[11.1-15.7]
HCT	46.4 H	%	[34.0-42.0]
MCV	85.5	FL	[80.0-100.0]
MCH	28.0	PG	[27.0-31.0]
MCHC	32.8	%	[31.0-36.9]
PLATELET	397	K/MM3	[150-450]
MPV	8.2 L	FL	[9.0-17.0]
GRAN%	75.8 H		[35.0-55.0]
LYMPH%	15.3 L		[29.0-49.0]
MONO%	7.5	%	[0.0-14.0]
EOS%	0.9	%	[0.0-6.0]
BASO%	0.5	%	[0.0-1.0]
NRBC%	0.0	%	[0.0-0.1]
ABS GRAN	6.4		[1.8-8.0]
ABS LYMPH	1.3 L		[1.5-6.8]
ABS MONO	0.6	K/MM3	[0.0-1.7]
ABS EOS	0.1	K/MM3	[0.0-0.7]
ABS BASO	0.0	K/MM3	[0.0-0.3]
RDW	12.7	%	[11.0-16.0]

CHEMISTRY

BASIC METABOLIC PANEL

Date 05/20/2004
Day of Stay Thu
Time 14:25:00

Procedure		Units	Ref Range
SODIUM	135	MMOL/L	[135-153]
POTASSIUM	4.8	MMOL/L	[3.5-5.3]
CHLORIDE	101	MMOL/L	[98-110]
CO2	23 L	MMOL/L	[24-31]
BUN	8	MG/DL	[5-25]
CREATININE	0.5	MG/DL	[0.5-1.5]

RESULT FLAGS:

- L Low Result
- H High Result
- C Corrected Result
- P Panic Value
- * Abnormal Result
- f There is a footnote (comment) associated with this result

University Medical Center of Southern Nevada

Department of Pathology

1800 West Charleston Blvd., Las Vegas, Nevada 89102
Carol van der Harten, M.D., Director of Laboratories

Patient Name :	PAYO, MAKANI K	Room :PEDS:0260-01		Print Date:	5/20/04
Hospital No. :	75603365	MRN : 1191358		DOB:	09/22/1992
Discharge Date :		Doctor: LAZERSON, JACK		Sex:	Male

CHEMISTRY

BASIC METABOLIC PANEL

Date	05/20/2004
Day of Stay	Thu
Time	14:25:00

Procedure		Units	Ref Range
GLUCOSE	104	MG/DL	[70-120]
CALCIUM	9.1	MG/DL	[8.7-10.6]
Anion Gap	11	MMOL/L	[8-16]

RESULT FLAGS:

L	Low Result	P	Panic Value
H	High Result	*	Abnormal Result
C	Corrected Result	f	There is a footnote (comment) associated with this result

0 0206
RA 0094

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

DEPARTMENT OF RADIOLOGY

1800 W. CHARLESTON BLVD. LAS VEGAS, NV. 89102
(702) 383-2241

Name: PAYO, MAKANI K
Sex: M **Age:** 11Y **Date of Birth:** 09/22/1992
Location: PED PEDS 26001 **Medical Record Number:** 001-191-358

Ordering Physician: JACK LAZERSON
Order Number: 90002 **Order Date:** 05/20/2004

Final Report

Exam Charge Date: May 20 2004 12:43PM
PROCEDURE: TCT 0018 TR CT BRAIN W/O CONTRAST - 3346783

CLINICAL HISTORY: TRAUMA.

TECHNIQUE: Routine computerized tomographic sections of the brain were obtained without intravenous contrast.

FINDINGS: The low cuts show a normal posterior fossa with adequately delineated fourth ventricle, brain stem, cerebellum and cerebellopontine angle cisterns.

High sections show normal midbrain, white and gray matter, third ventricle, pineal, lateral ventricles, cisterns and cerebral sulci. No high or low density lesions are seen.

IMPRESSION:

NORMAL EXAMINATION.

CR/cja

Interpreting Radiologist: CARL RECINE M.D.

Transcribed By: CA: May 20 2004 1:00P

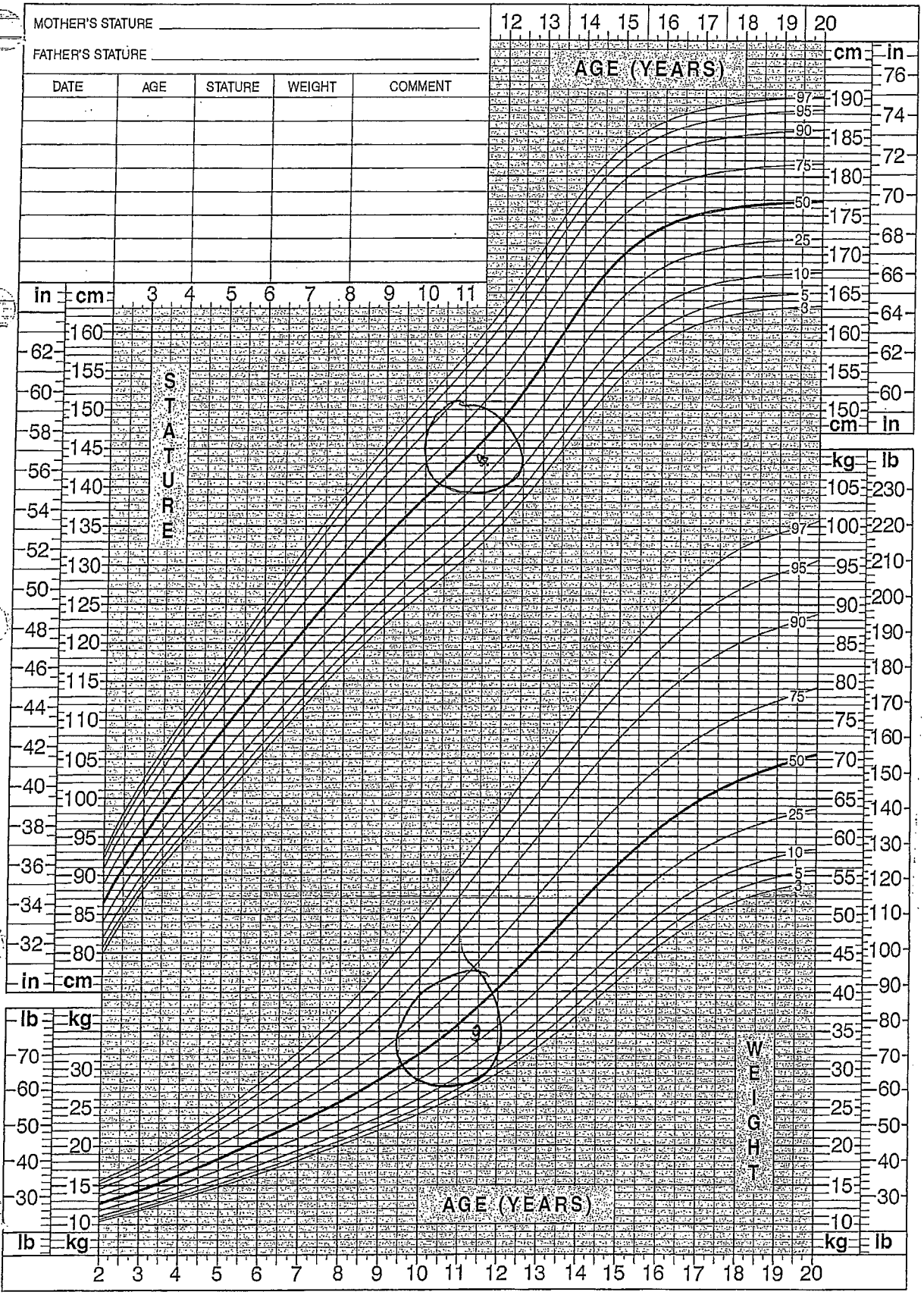
BOYS: 2 TO 20 YEARS
CDC US GROWTH CHARTS*

Name _____ Record #_____

MOTHER'S STATURE _____

FATHER'S STATURE _____

DATE	AGE	STATURE	WEIGHT	COMMENT



ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K ADM 05/19/2004
LAZERSON, JACK
MR# 001-191-356

National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al: CDC Growth Charts, United States. Advance data from vital and health statistics No. 314. Hyattsville, Maryland: National Center for Health Statistics, December 4, 2000.

This chart is consistent with CDC growth data as of July 2001.

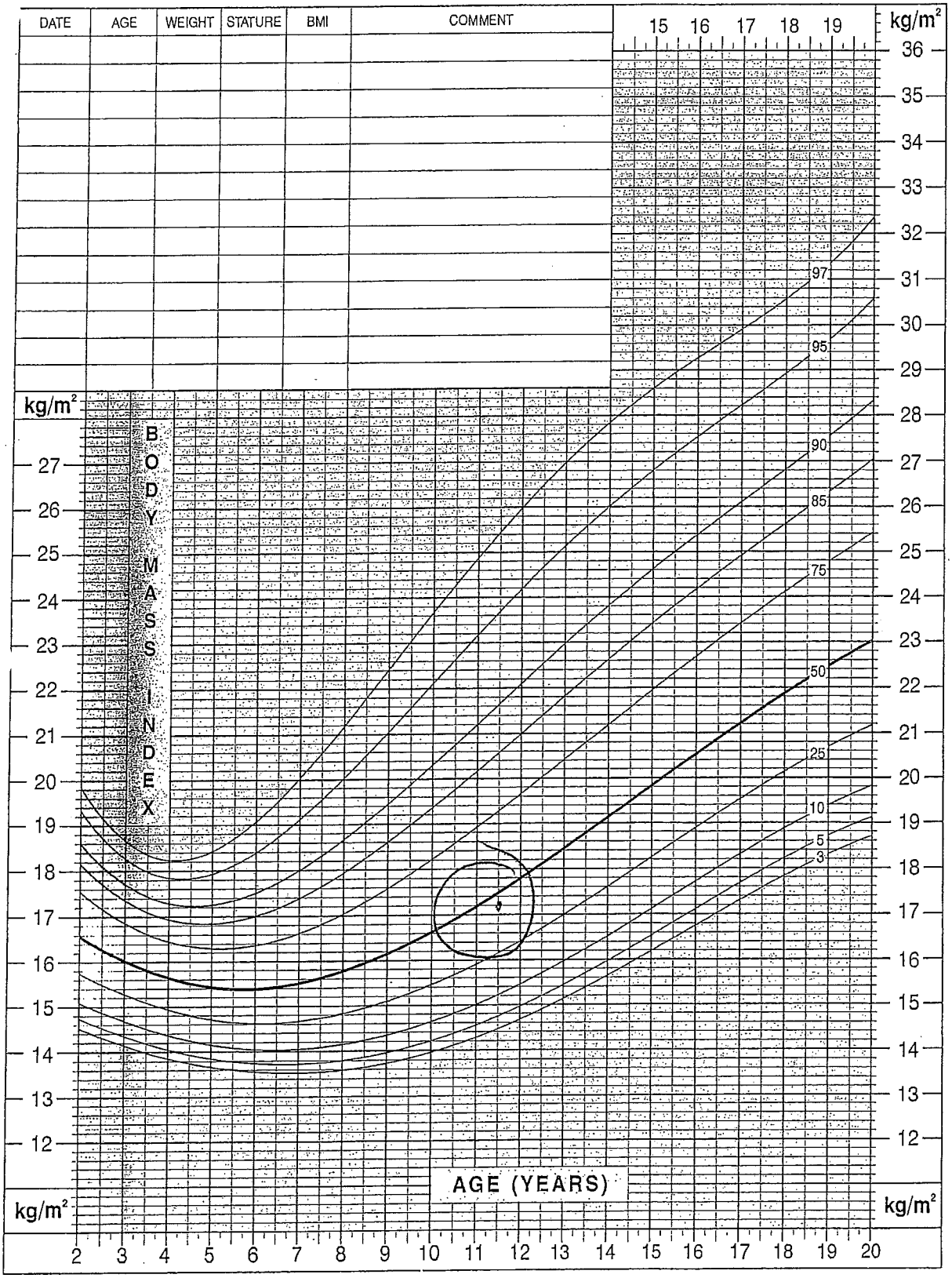
Internet: http://www.cdc.gov/growthcharts

0 0208

BOYS: 2 TO 20 YEARS
CDC US GROWTH CHARTS
BODY MASS INDEX (BMI)*

Name _____ Record #_____

DATE	AGE	WEIGHT	STATURE	BMI	COMMENT



* Adapted from the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). Kuczmarski RJ, Ogden CL, Grummer-Strawn LM, et al: CDC Growth Charts, United States. Advance data from vital and health statistics No. 314. Hyattsville, Maryland: National Center for Health Statistics, December 4, 2000.

This chart is consistent with CDC growth data as of July 2001.

Internet: http://www.cdc.gov/growthcharts

Calculating Body Mass Index

Metric Formula: Weight in kilograms ÷ Stature in centimeters ÷ Stature in centimeters x 10,000 = BMI (kg/m²)

English Formula (fractions/oz must be entered as decimal values): Weight in pounds ÷ Stature in inches ÷ Stature in Inches x 703 = BMI (kg/m²)

0 0209

51212
(0.05)/JULY 2001

ROSS PRODUCTS DIVISION
ABBOTT LABORATORIES INC.
COLUMBUS, OHIO 43215-1724

RA 0097

UMC

SCHEDULED MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 1.18
		143
		CrCl:

CHECKED BY:

DATE 05/23/2004 07:00 To: 05/24/2004 07:00

		FIRST DOSE RESPONSE/ COMMENTS
05/22/04 ATROPINE 1% EYE DROPS 15ML 06/21/04 **GIVE 1DROP OPHTH MULTI** (4858305) 1 DROPS IN LEFT EYE TID 08-16-24 4 en minutes between g#s.	0800 qn Hold	Hold Atropine eyedrops
05/22/04 PrednisoLONE ACET. 1% EYE DROPS 06/21/04 **GIVE 1 DROP OPHTH MULTI** (4858306) 1 DROP IN LEFT EYE Q 3 HRS WHILE AWAKE SHAKE WELL ✓	0800 qn 1100 qn 1400 qn	
05/22/04 TIMOLOL 0.5% EYE DROPS 06/21/04 **GIVE 1DROP OPTH BID** (4858309) ~~08:00 20:00~~ 16-04 INSTILL ONE DROP IN LEFT EYE(OS) BID 10 min between g#s.	1600 qn	
05/22/04 TOBRAMYCIN 0.3% EYE OINTMENT 06/21/04 **GIVE APPLY OPHTHALMIC TID** (4860847) 08:00 14:00 20:00 1/8 INCH TO LEFT EYE TID ✓	0800 qn 1400 qn	
05/21/04 KCL 10MEQ In D5 1/2 NACL 500 ML 06/20/04 IV ~~at 200 ML/HR~~ 100 cc (4858312) ✓ F	0730 hr Infusing 1200 D CM	

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

UMC

PRN MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 1.18
		143
		CrCl:

CHECKED BY:

DATE 05/23/2004 07:00 To: 05/24/2004 07:00

	FIRST DOSE RESPONSE/ COMMENTS
05/21/04 ACETAMINOPHEN 500MG CAPLET 06/20/04 **GIVE 500MG ORAL PRN** (4858307) Q4-6HR PRN HEADACHE MAXIMUM DAILY DOSE =4000MG F	0845 gn 1245 gn
05/21/04 ONDANSETRON 4MG/2ML INJ 06/20/04 **GIVE 4MG INTRAVEN. PRN** (4858311) Q4HRS PRN F	1125 gn

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

UMC

SCHEDULED MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 1.18
		143
[signature]	[initials]	CrCl:

CHECKED BY: [signature]

at least 10 Minutes Between Eyegtts.

DATE 05/22/2004 07:00 To: 05/23/2004 07:00

Order		Times	FIRST DOSE RESPONSE/ COMMENTS
5/22 05/22/04 ATROPINE 1% EYE DROPS 15ML 06/21/04 GIVE LEFT EYE OPTH MULTI i gtt (4858305) TID	✓	1800 24 bm	
5/22 05/22/04 PrednisoLONE ACET. 1% EYE DROPS 06/21/04 GIVE 1 DROP LEFT EYE Q3 while awake (4858306) 09:00 12:00 15:00 18:00 21:00 00:00 03:00 06:00 WHILE AWAKE Predforte.	✓	1550 [initials] 1930 [initials] (2230) asleep. 0025 bm.	
5/22 05/22/04 TIMOLOL 0.5% EYE DROPS 06/21/04 GIVE 1DROP OPTH BID (4858309) 08:00 20:00 INSTILL ONE DROP IN LEFT EYE(OS) BID	✓	1630 [initials] 0430 bm.	
05/21/04 DORZOLAMIDE 2% EYE DROPS 06/20/04 GIVE 1 DROP OPHTHALMIC MULTI (4858310) 1 DROP IN LEFT EYE BID Trusopt	✓	Hold D/C 5/22	
05/21/04 KCL 10MEQ in D5 1/2 NACL 500 ML 06/20/04 IV ~~at 200 ML/HR~~ 100 cc (4858312) F	✓	1040 [initials] 1750 22 bm. 0230 bm	
TObrex ung 1/8" LefT EYE T.I.D.		2150 bm.	1735 NOT AVAIL
DIAMOX D/C'd 5/22			

0 0212

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

UMC

PRN MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 1.18
		143
		CrCl:

CHECKED BY:

DATE 05/22/2004 07:00 To: 05/23/2004 07:00

	FIRST DOSE RESPONSE/ COMMENTS
05/21/04 ACETAMINOPHEN 500MG CAPLET 06/20/04 **GIVE 500MG ORAL PRN** (4858307) Q4-6HR PRN HEADACHE MAXIMUM DAILY DOSE =4000MG F	0740 6/10 Dose. 1950
05/21/04 ONDANSETRON 4MG/2ML INJ 06/20/04 **GIVE 4MG INTRAVEN. PRN** (4858311) Q4HRS PRN F	

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

UMC

SCHEDULED MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 1.18
		143
		CrCl:

CHECKED BY:

DATE 05/21/2004 07:00 To: 05/22/2004 07:00

		FIRST DOSE RESPONSE/ COMMENTS
05/19/04 AcetaZOLAMIDE 500MG INJ 06/18/04 **GIVE 125MG INJECTION BID** (4849664) 08:00 20:00 100-500mg/minute for IV push 09-21 Diamox	900 kg 2100 jm	
05/19/04 WATER,STERILE FOR INJ 06/18/04 **GIVE 10ML INJECTION BID** (4849665) 08:00 20:00 USE FOR ACETAZOLAMIDE RECONSTITUTION		
05/19/04 DORZOLAMIDE 2% EYE DROPS 06/18/04 **GIVE 1 DROP OPHTHALMIC MULTI** (4849886) 1 DROP IN LEFT EYE BID frusopt 18-06	1800 06 Hold until AM	
05/19/04 TIMOLOL 0.5% EYE DROPS 06/18/04 **GIVE 1DROP OPTH BID** (4850410) 08:00 20:00 INSTILL ONE DROP IN LEFT EYE(OS) BID 08-20	0800 kg Hold until AM	
05/19/04 KCL 10MEQ in D5 1/2 NACL 500 ML 06/18/04 IV at 100 ML/HR (4849647) F	0005 AM 05 AM	
Atropine 1% Tgtt OU eye TID	Hold until AM	
Pred fort 1% Tgtt OU eye. q3hr	Hold until AM	

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

UMC

PRN MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 1.18
		143
		CrCl:

CHECKED BY:

DATE 05/21/2004 07:00 To: 05/22/2004 07:00

		FIRST DOSE RESPONSE/ COMMENTS
05/19/04 MORPHINE SULFATE 2-3MG INJ 05/24/04 **GIVE 2MG INTRAVEN. PRN** (4849650) ..DILUTE DOSE IN 5ML 0.9% NACL FOR IV USE Q4HRS PRN PAIN F	8.10 kg 2040 #	
05/19/04 ONDANSETRON 4MG/2ML INJ 06/18/04 **GIVE 4MG INTRAVEN. PRN** (4849661) Q4HRS PRN F	✓	
05/20/04 ACETAMINOPHEN 500MG CAPLET 06/19/04 **GIVE 500MG ORAL PRN** (4851867) Q4-6HR PRN HEADACHE MAXIMUM DAILY DOSE =4000MG F	✓ 23 Hr	

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

UMC

SCHEDULED MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INITS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 0
		CrCl:

CHECKED BY:

DATE 05/20/2004 07:00 To: 05/21/2004 07:00

		FIRST DOSE RESPONSE/ COMMENTS
05/19/04 AcetaZOLAMIDE 500MG INJ 06/18/04 **GIVE 125MG INJECTION BID** (4849664) 08:00 20:00 100-500mg/minute for IV push Diamox 08-20	0940 CM 2130	NOT AVAIL Scan → Pharm. B/A 99/65
05/19/04 WATER,STERILE FOR INJ 06/18/04 **GIVE 10ML INJECTION BID** (4849665) 08:00 20:00 USE FOR ACETAZOLAMIDE RECONSTITUTION		
05/19/04 DORZOLAMIDE 2% EYE DROPS 06/18/04 **GIVE 1 DROP OPHTHALMIC MULTI** (4849886) 1 DROP IN LEFT EYE BID Trusopt. 18 - 06	18 06	
05/19/04 TIMOLOL 0.5% EYE DROPS 06/18/04 **GIVE 1DROP OPTH BID** (4850410) 08:00 20:00 INSTILL ONE DROP IN LEFT EYE(OS) BID 08 - 20	08 20	
05/19/04 KCL 10MEQ In D5 1/2 NACL 500 ML 06/18/04 IV at 100 ML/HR (4849647) F	1000	

0 0216

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

RA 0104

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PRN MAR

260-01 AREA: PEDS ACCT #: 00075603365
PAYO, MAKANI MR #: 001-191-358
BIRTH DATE: 09/22/1992 AGE : 11 YRS
Dr. LAZERSON, JACK

SIGNATURE	INTS.	ALLERGIES/HT./WT.
		NKDA
		35 Kg BSA: 0
		CrCl:

CHECKED BY:

DATE 05/20/2004 07:00 To: 05/21/2004 07:00

		FIRST DOSE RESPONSE/ COMMENTS
05/19/04 MORPHINE SULFATE 2-3MG INJ 05/24/04 GIVE 2MG INTRAVEN. PRN (4849650) ..DILUTE DOSE IN 5ML 0.9% NACL FOR IV USE Q4HRS PRN PAIN F	No 20 gr (2mg)	4/10 64 SR
05/19/04 ONDANSETRON 4MG/2ML INJ 06/18/04 GIVE 4MG INTRAVEN. PRN (4849661) Q4HRS PRN F		
5/20/04 Tylenol 500 mg PO Q4-6 PRN H/A.	1 tab	H/A

0 0217

CIRCLE=Not given, state reason DC=Discontinued Indicate site for all injections

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UNIVERSITY MEDICAL CENTER
Care How Much We Know
Know How Much We Care.

MEDICATION ADMINISTRATION RECORD

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

SIGNATURE	INTS.	ALLERGIES/HT./WT.
G Guerrero RN	GG	35 Kg 143 cm

CHECKED BY: GG

DATE 5-19-04 - 5-20-04		COMMENTS
5-19-04 GG 500cc .9 NaCL over 1 hours	1630 GG	
5-19-04 D5 1/2 NS ē 20meq KCL/L @ 100cc/hr	1800 GH	
5-19-04 Trusopt Tgtt in (L) eye BID	18:40 GBS 06:30 G	OK to use homesuppy
5-19-04 Diamox 125mg IV BID	20:00 G	
Timolol 0.5% T gtt OS BID	20:00 G	

0 0218

P & P 1233709 FORM # 164 (4/99)

CIRCLE – Not given, state reason DC – Discontinued Indicate site

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UNIVERSITY MEDICAL CENTER
Care How Much We Know
Know How Much We Care.

MEDICATION ADMINISTRATION RECORD

ACCT: 007S603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

SIGNATURE	INTS.	ALLERGIES/HT./WT.
G Guerriero RN	GG	35Kg 143cm
Mayo	g	

CHECKED BY: GG

DATE 5-19-04 - 5-20-04		COMMENTS
5-19-04 Zofran 4mg IV Q4hrs prn		
5-19-04 Morphine Sulfate 2mg IV Q4hrs prn pain	2mg 18:40	

0 0219

P & P 1233709 FORM # 164 (4/99)

CIRCLE – Not given, state reason DC – Discontinued Indicate change in time or dose

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ACCT: 0075603365 DOD 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

ADMISSION ASSESSMENT

PEDIATRICS - Page 1 of 6

ADMISSION DATA

Admitting Diagnosis (L) Ocular pressure/Traumatic Glaucoma
Parents / Guardian Name & Phone Number
Lori 702 491-1913
Step-parent / Contact person & Phone Number
Custodian / Primary Caregiver & Phone Number
Arrived Via ☒ Wheelchair ☐ Stretcher ☐ Ambulatory
☐ Carried ☐ Direct Admit ☒ ER ☐ Surgery ☐ Other
Date 05/19/04 Time 16:00
Weight(Actual) 35 Kg Stated lbs
Height 143 cm inches
Head Circumference N/A cm Abd. Circumference N/A cm
Temp 100° Route PO Pulse 60 Resp. 24
B/P 117/69 Cuff Size adult BMI BSA
Birth History: Place of Birth
Type of birth / Complications
Information Source: ☐ Patient ☐ Parents ☐ Other
Correct Patient Armband on ☐ Yes ☐ No
Restrictions on visitors ☐ Yes Specific ☐ No

Initials

ALLERGIES & REACTIONS

☒ NKA ☐ Medication ☐ Food ☐ Iodine ☐ Latex/Balloons
☐ Contrast Media ☐ Dye ☐ Kiwi ☐ Bananas
☐ Adhesive tape ☐ Chemical ☐ Environmental
☐ Anesthesia ☐ Pet in Home ☐ Yes ☐ No

LIST	EFFECT

TRANSFUSION:
Past Transfusions ☐ Yes ☐ No Date
Blood Reactions ☐ Yes ☐ No Effect
Restrictions (Religious, Other)
Initials
☐ Admitting physician notified of admission. Time
Initials

MEDICATION

Include Herbal Medications / OTC / Vitamins

Current Meds	Dose	Frequency	Last Taken

☐ See Emergency Department

* Do you take >5 medications on a regular basis? ☐ Yes ☐ No
Did you bring your child's medications with you? ☐ Yes ☐ No
Does your child take medicine(s) every day? ☐ Yes ☐ No
Where do you have your child's prescriptions filled?

Is your child on a clinical trial? ☐ Yes ☐ No Drug/Device

☐ No problem identified ☐ Problem addressed on IPOC
*Referral to Pharmacy
Initials

MEDICAL HISTORY / IMMUNIZATION

Status prior to admission Normal, active healthy child
History of present illness Playing field hockey @ school on 05/12. Hit in (L) eye c hockey stick.
Duration of symptoms One week How long does the parent/patient expect hospitalization to last?
Primary care Physician Admitting Physician Dr. Lazerson
Parent's expectation on impact of hospitalization
Infectious Disease History ☐ None ☐ Varicella ☐ Mumps ☐ Rubella ☐ Rubeola ☐ Pertusis ☐ TB ☐ Hep B ☐ Synagis
Travel outside the area in last 3 months? ☐ Yes ☐ No Last PPD skin test Negative Positive / treatment status
Immunization: ☐ Current ☐ Immuno-compromised ☐ Not current ☐ Date of last immunization
☐ HIB ☐ DTap ☐ Polio ☐ Hep B ☐ Hep A ☐ MMR ☐ Varicella ☐ PPD ☐ Pneumococcus ☐ Other

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UNIVERSITY MEDICAL CENTER

ADMISSION ASSESSMENT

ACCT: 0075603365 DOD 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PEDIATRICS Page 2 of 6

MEDICAL HISTORY (con't)

Respiratory ☒ NA ☐ Specify _____
Cardiovascular ☒ NA ☐ Specify _____
Endocrine/Renal ☒ NA ☐ Specify _____
Hematology/Oncology ☒ NA ☐ Specify _____
Infectious Disease ☒ NA ☐ Specify _____
Neurological ☒ NA ☐ Specify _____
Gastrointestinal ☒ NA ☐ Specify _____
Musculo-skeletal ☒ NA ☐ Specify _____
Psychological ☒ NA ☐ Specify _____

Prior surgery Yes No Type _____ When _____ Where _____

FAMILY MEDICAL HISTORY:

Pulmonary ☒ NA ☐ Specify _____
Cardiovascular ☒ NA ☒ Specify CHF - Maternal Grandmother
Endocrine ☐ NA ☒ Specify Diabetes Paternal Grandmas.
Neurological ☒ NA ☐ Specify _____
Immune System ☒ NA ☐ Specify _____
GI disorder ☒ NA ☐ Specify _____

Any other medical history None
☒ No problem identified ☐ Problem addressed on IPOC Initials _____

ASSISTIVE DEVICES

☒ None
Hearing impairment ☐ Yes ☐ No Specify _____
Retainers/braces/loose teeth or caps ☐ Yes ☒ No Specify _____
Others Specify _____
Initials _____
Visual impairment ☒ Yes ☐ No Specify Near-sighted Glasses.
Orthotics ☐ Yes ☐ No Specify _____

SOCIAL SCREEN

Repeat admission
Are there custody issues ☐ Yes ☐ No
Parents Marital Status _____
Place of Residency _____
People who reside with patient ☐ Siblings ☐ Pets
☐ Other _____
Victims of child abuse ☐ Yes ☐ No ☐ Emotional problems
Patient/Family exhibits effective coping mechanisms
☐ Yes ☐ No

Tobacco use: ☐ Used ☐ Exposed (by) _____
Recreational Drugs ☐ Yes ☐ No ☐ Unknown
Type _____ Amount _____ Last Use _____
Alcohol ☐ Yes ☐ No ☐ Unknown
Type _____ Amount _____ Last Use _____
Drug or rehab program attended ☐ Yes ☐ No
Explain _____

☐ No problem identified ☐ Problem addressed on IPOC
Referral to Social Services ☐ Order# _____ Initials _____
Referral to Nevada Tobacco Help Line Order# _____ Initials _____
Initials _____

DISCHARGE PLANNING SCREEN

Environmental Concerns: Is adequate... ☐ Housing
☐ Plumbing ☐ Heating / Air ☐ Cooking facilities
Will patient/parent need post discharge assistance? ☐ Yes
☐ No ☐ Unknown ☐ Other _____
Will assistance be needed beyond which the family can provide?
☐ Yes ☐ No ☐ Unknown Other _____
▲ Financial / Insurance concern ☐ Yes ☐ No ☐ Unknown
Who do we notify for discharge? _____

Does patient have someone to provide care after discharge?
☐ Yes ☐ No ☐ Unknown
If yes, who: _____ phone no. _____
Initials _____

☐ No problem identified ☐ Problem addressed on IPOC
Referral to Social Services ☐ Order# _____ Initials _____
▲ Referral to Financial Services Initials _____
Initials _____

CULTURAL / SPIRITUAL NEEDS SCREEN

☐ Ritual requested ☐ Ethnic / Cultural practices requested
Spiritual Support Requested ☐ Yes ☐ No

Special religious practices: ☐ Prayer ☐ Scripture
☐ Communion ☐ Other, explain _____

Will your religious or cultural beliefs have an impact on proposed medical treatment? ☐ Yes ☐ No
If yes, explain _____
☐ No problem identified ☐ Problem addressed on IPOC
☐ Referral to Social Services Order# _____ Initials _____
☐ Referral to Spiritual Services Initials _____
Initials _____

UNIVERSITY MEDICAL CENTER

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

ADMISSION ASSESSMENT

PEDIATRICS Page 3 of 6

NUTRITIONAL RISK SCREEN

< 5th or > 95th percentile Growth Charts				
weight / age	☐ Yes	☒ No		
Weight / height	☐ Yes	☒ No		
BMI / age	☐ Yes	☒ No		
Head circumference if <3 years old	☐ Yes	☒ No		
Unintentional 10% weight loss 1 month	☐ Yes	☒ No		
Organ failure: renal, hepatic, respiratory and or cardiac	☐ Yes	☒ No		
Pressure Ulcer / Chronic Wound	☐ Yes	☒ No		
Poor appetite > 10 days	☐ Yes	☒ No		
*Difficulty chewing / swallowing/sucking	☐ Yes	☒ No		
Strict vegetarian			☐ Yes	☒ No
Family request for special diet / concerns			☐ Yes	☒ No
Burn			☐ Yes	☒ No
Special diet or medical/religious/ethnic food preference			☐ Yes	☒ No
Food allergy or intolerance			☐ Yes	☒ No

☐ No problem identified ☒ Problem addressed on IPOC
Referral to Nutritional Services ☐ Order# _____ Initials ____
Referral to Speech Therapy ☐ Order# _____ Initials ____
If Yes responses checked, please initiate nutritional referral.
Initials GY

FUNCTIONAL SCREEN

Age appropriate independence with all aspects Infant Toddler

A Ambulation	I Bathing	I Toileting
I Feeding	I Dressing	I Transfer

LEGEND: I=Independent IA=Independent with Assistance
A=With Assistance D-Dependent

☒ No problem identified ☐ Problem addressed on IPOC

Initials GY

NUTRITIONAL GI/GU STATUS

Pre-admission diet ☒ Regular ☐ Other ____ ☐ Last P.O. intake _____
Adequate oral intake ☐ Yes ☒ No
Enteral/parenteral feeding or supplement ☐ Yes ☒ No Specify _____
GT /Button size NA
Did they bring catheter for button? ☐ Yes ☒ No
☐ Breast ☐ Bottle ☐ Cup ☐ Baby Food ☐ Table Food
Food likes _____ Food dislikes _____
Formula _____ Amount/frequency _____
Do you have any dietary need or concerns ☒ Yes ☐ No
Feeding Problem ☐ Yes ☐ No Constipation/Diarrhea ☐ Yes ☐ No
Nausea/Vomiting ☒ Yes ☐ No Unconscious/Intubated ☐ Yes ☐ No
Term for urine _____ Stool _____
Diapers ☐ Yes ☒ No Cloth ☐ Yes ☐ No
Toilet trained ☒ Yes ☐ No

DENTAL HEALTH:

Does your child have regular Dental Health checkups and cleaning ☐ Yes ☐ No
Would you like a referral for Dental needs? ☐ Yes ☐ No
Growth chart plotted Date _____ Time _____
☐ No problem identifed ☐ Problem addressed on IPOC

Referral to Nutritional Services Order#_____ Initials

Initials _____

EDUCATIONAL NEEDS / PROVISIONS ASSESSMENT

Impairments/Barriers to learn.
Physical ☐ Yes ☒ No Cognitive ☐ Yes ☒ No
Reading ☐ Yes ☒ No Writing ☐ Yes ☒ No
Emotional / Motivational ☐ Yes ☒ No Religious / Cultural ☐ Yes ☒ No
Is your primary language English ☒ Yes ☐ No
Interpreter needed ☐ Yes ☒ No Language _____
How do you prefer to learn? Discussion Reading Demonstration
Audio Visual
Medications: Dosage ☐ Yes ☐ No Indication ☐ Yes ☐ No
CPR Training: Has had ☐ Yes ☐ No Need ☐ Yes ☐ No
Respiratory Care: Spacers ☐ Yes ☐ No SVN's ☐ Yes ☐ No
Peak Flows ☐ Yes ☐ No Medications ☐ Yes ☐ No

Home Safety/Environmental Safety ☐ Bike ☐ Home ☐ Car
☐ Car Seat ☐ Seat Belts
Would you like to have your car seat checked? ☐ Yes ☐ No
Financial implications of care ☐ Yes ☐ No
What is your #1 concern or need relative to this episode of care?

☐ No problem identified ☐ Problem addressed on IPOC

Initials _____

0 0222

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UNIVERSITY MEDICAL CENTER

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

ADMISSION ASSESSMENT

PEDIATRICS - Page 4 of 6

PSYCHOLOGICAL SCREEN

☒ Cooperative ☐ Uncooperative ☐ Anxious ☐ Withdrawn
☐ Confused ☐ Restless ☐ Calm ☐ Depressed ☐ Other
Do you have a lot of stress on patient/parents ☐ Yes ☒ No
Explain _____
Losses in the last 12 months ☐ Job ☐ Marriage ☐ Family ☐ Friend
Special fears: _____
Normal bedtime _____ Nap time _____ Security _____

School Age/Adolescent? Are there any issues that you are concern about? ☐ Yes ☐ No Specify _____

Notify Physician
☐ No problem identified ☐ Problem addressed on IPOC
Initials _____

DEVELOPMENTAL MILESTONES

INFANT

☐ WNL ☐ Not Met

0-6 Months
☐ Cries
☐ Smiles
☐ Startles to loud sounds
☐ Rolls to side
☐ Lifts head in prone to 90º

6 mos.
☐ Localizes sound
☐ Grasp with one hand

mos.
☐ Sits with support
☐ Rolls abdomen to back

10 mos.
☐ Creeps rolls
☐ Stands while holding on

12 mos.
☐ Stands with support
☐ Verbalizes 2-3 words

TODDLER

☐ WNL ☐ Not Met

15mos
☐ Walks alone
☐ Imitates
☐ Several Intelligible words

18 mos
☐ Walks up and down the stair while holding on
☐ Many Intelligible words
☐ Carries out simple commands

1-2 yrs.
☐ Runs with occasional fall
☐ Walks up and down stairs by self
☐ 2-3 word phrases
☐ Jumps with one hand held
☐ Vocalizes questions
☐ Builds tower with blocks

☒ WNL ☐ Not Met
Age approp. Delayed
Fine motor
Gross motor
Speech

Grade in school 6th
Anticipate homebound or alternative plan for homework _____
Are there any adolescent issues you would like to discuss? _____

Age menses onset _____ ☒ N/A
Last menses date _____
Sexually active? ☐ Yes ☒ No
If yes, birth control method —
Last PAP smear —
Possible pregnancy ☐ Yes ☐ No ☐ N/A
Sexually transmitted disease ☐ Yes ☐ No
Initials GG

PAIN ASSESSMENT

Is your child in pain now? ☐ Yes ☒ No Location _____ Duration _____ Freq _____ Description _____
On a scale from 0-10, what is the level of your child's pain at this time? 0 X 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
What word does your child use in reference to pain? It hurts How do you know when your child is in pain? He will tell you
How do you relieve your child's pain at home? _____
Would you like some information about pain and anxiety relief for your child? NO
Do you know about our Child Life Program ☐ Yes ☒ No

Initials GG

ASSESS	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn disinterested	Frequent to constant, quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arches, rigid or jerking
CRY	No cry (Awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching hugging or being talked to distractible	Difficult to console or comfort

UMC UNIVERSITY MEDICAL CENTER

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

ADMISSION ASSESSMENT

PEDIATRICS - Page 5 of 6

NEUROLOGICAL

ORIENTED: Person: ☒ Yes ☐ No
Place ☒ Yes ☐ No
Time ☒ Yes ☐ No

LOC: ☒ Alert ☐ Deficit

PUPIL: R ☐ Equal ☒ Reactive ☐ Deficit _____
L ☐ Equal ☐ Reactive ☒ Deficit corneal hemmorhage

SENSORY/MOTOR: ☒ Intact ☐ Deficit

EXTREMITY STRENGTH: ☐ Upper: ☒ Equal ☐ Unequal
Lower: ☒ Equal ☐ Unequal Paraplegia
☐ Quadriplegic ☐ Hemiplegia L_____ R_____

HEARING: ☒ No deficit ☐ Loss of Hearing L___ R___ ☐ Deaf

SPEECH: ☒ Clear ☐ Slurred ☐ Nonverbal
☐ Aphasic ☐ Expressive ☐ Receptive

COGNITION: ☒ Intact ☐ Deficit _____

CARDIO / VASCULAR

COLOR: ☒ Normal ☐ Pale ☐ Mottled ☐ Dusky ☐ Cyanotic
☐ Jaundice ☐ Flushed

RHYTHM: ☐ NSR ☐ Other _____

PULSES: Code P=Present A=Absent D=Doppler
☒ Regular ☐ Irregular: Radial R✓ L✓
Pedal R___ L___

EDEMA: ☒ None ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Location _____

PERFUSION: ☒ Warm ☐ Dry ☐ Diaphoretic ☐ Cool ☐ Clammy
CAPILLARY REFILL ☒ Brisk ☐ >3 seconds

PACEMAKER ☐ Yes ☒ No _____

VENOUS ACCESS DEVICE ☒ Yes ☐ No (L) AC _____

RESPIRATORY

AIRWAY: ☒ Normal ☐ Trach ☐ ET Type _____ Size _____

ASSISTIVE DEVICE: ☒ None ☐ Vent _____

RESPIRATORY EFFORT: ☒ No Distress ☐ SOB ☐ Dyspnea
☐ Use of accessory muscles ☐ Nasal ☐ Flaring

Rate: ☒ Eupnea ☐ Bradynea ☐ Tachypnea ☐ Apnea
☐ Grunting ☐ Stridor

BREATH SOUNDS:

	Right	Left
Clear/Equal	☒	☒
Absent	☐	☐
Wheezes	☐	☐
Diminished	☐	☐
Crackles	☐	☐

COUGH/SECRETIONS: ☒ None ☐ Non-productive
☐ Productive Type / Color _____

GASTROINTESTINAL

DIET ☐ Regular ☒ Special: Type/Method Clears
☐ Tolerance ☐ No Deficits ☒ Nausea ☒ Vomiting

ABDOMEN: ☒ Soft ☒ Flat ☐ Distended ☐ Rigid ☐ Tender
ABD. Girth _____ cm

BOWEL FUNCTIONS: ☒ Continent/Controlled ☐ Daily/regular
☐ Incontinent ☐ Diaper ☐ Diarrhea=? times in last 24º _____
☐ Constipation ☐ Melena ☐ Last BM _____
☐ Laxative Use ☐ Colostomy
☐ Fecal pouch ☐ Ileostomy

BOWEL SOUNDS: ☒ Normal ☐ Hypo ☐ Hyper ☐ Absent

GENITOURINARY

URINARY: ☒ No problems ☐ Anuria ☐ Hematuria
☐ Diaper ☐ Dysuria ☐ Nocturia ☐ Incontinent
☐ Urgency ☐ Hesitancy ☐ Ostomy
☐ Discharge ☐ Dialysis _____

Catheter: ☐ Yes ☒ No Date _____
Type / Size _____

GENITALS: ☐ Normal ☐ Red ☐ Swollen ☐ Excoriated
Not assessed ☐ Discharge _____

INTEGUMENTARY

SKIN: ☒ Intact
Breakdown: ☐ Rash ☐ Blisters ☐ Erythema ☐ Lesions
Location (L) eye abrasion upper eyelid

SKIN TURGOR: ☐ Good ☐ Fair ☐ Poor

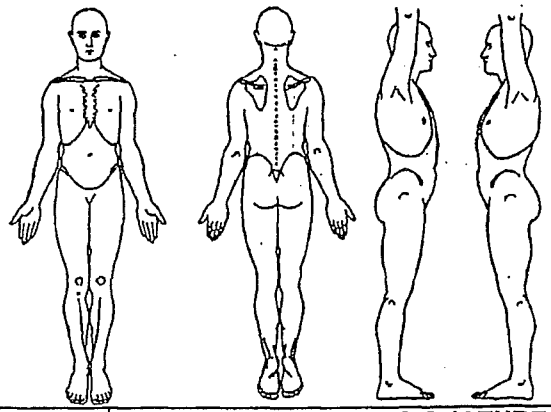
MUCOUS MEMBRANES: ☒ Moist ☐ Dry ☐ Cracked ☐ Lesions

WOUNDS: Type As above
Location (L) periorbital eye

SIGNS OF PHYSICAL ABUSE

☐ Bruising ☆ _____ ☐ Petechiae △ _____
☐ Tears/Lacerations ☐ _____
☐ Discharge _____
☐ Burns X _____
☐ Others _____
☐ Abrasions ○ _____

INSTRUCTIONS:
Place symbol on appropriate body location



INITIALS	SIGNATURE
GG	G Guerrero RN
	0 0224

RA 0112

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UNIVERSITY MEDICAL CENTER

ADMISSION ASSESSMENT

ACCT: 0075603365 DOB 09/22/1992
PAYO, HAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

PEDIATRICS Page 6 of 6

FALL / RESTRAINT / BED ENTRAPMENT PREVENTION SCREEN

Direction: Circle point values of all that apply and add for a total score. **Minimum level is 1 for all patients.**
Write total score in the space provided.

RISK FACTOR	RISK POINTS
Uneasy / restless / tense / combative	+3
Medication (sedation, diuretics, anti-hypertensives, pain, sleeping anti-anxiety, or anti-psychotic) 3 or more	+4
Altered elimination (incontinence, nocturia, frequency)	+3 ☐ NA
Recent history of fall (not a slip or trip) within the last 3 months	+7
Non-adaptive mobilitiy (generalized weakiness)	+2
Dizziness / vertigo / syncope	(+3)
Impaired communication / senses	+3 ☐ NA
Seizure disorders	+3
Other (Pulling out IV, IV lines, or tubes, trying to get OOB). Describe	+3
None	0

Level 1	Normal / low risk = 0 - 2 points
Level II	High Risk = 3 - 6 points
Level III	Extremely High Risk = 7 - 12 points
Level IV	≥ 12 points; failed Level I, II, III interventions, is clear potential danger to self/others, attempt less restrictive measures before considering restraints.

Circle Level of Intervention Total Score 3 Level One

Level I	Level II	Level III	Level IV
Call light and personal items in reach of patient.	Yellow armband on patient.	Bedside commode if indicated.	Toileting every 2 hours.
d in low position / brakes locked	Falling star on chart and patient's door	Reorient patient to time, place, person, every shift.	Companion (family)
Assistance with elimination as needed.	Night light / bathroom light for evening / night	Bedpan or urinal within reach.	Diversional activity while awake
Side rail position as appropriate, up for all sedated patients.	Status rounds every two hours.	Request family to stay with patient.	Plus all Level I, II, and III interventions.
Nonslip footwear, assist as needed	Plus all Level I interventions.	Plus all Level I and II interventions	

Initials NBS

SKIN RISK ASSESSMENT

RISK FOR SKIN BREAKDOWN - BRADEN SCALE
CIRCLE APPROPRIATE NUMBER

Sensory Perception		Moisture		Activity	
Completely limited	1	Constantly moist	1	Bedfast	(1)
Very limited	2	Moist	2	Chairfast	2
Slightly limited	3	Occasionally moist	3	Walks occasionally	3
No impairment	(4)	Rarely moist	(4)	Walks frequently	4

Mobility		Nutrition		Friction and Shear	
Completely immobile	1	Very poor	(1)	Significant problem	1
Very limited	2	Prob. Inadequate	2	Problem	2
Slightly limited	(3)	Adequate	3	Potential problem	3
No impairment	4	Excellent	4	No apparent problem	(4)

Risk Assessment Total Score: 17

Braden Scale: **21-24** = Static / Foam (low risk) **18-21** = Static / Foam (moderate risk) 15-17 = Low airloss / overlay (high risk)
0-14 = Specialized bed / air fluidized therapy when appropriate for age (high risk)

Impaired Skin Integrity: ☒ None ☐ Actual ☐ Potential Initials NBS

GeoMatt Ordered

0 0225

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Care How Much We Know. Know How Much We Care.

INTERDISCIPLINARY PATIENT PLAN OF CARE

SIGNATURE	INT.	DISCIPLINE
G Guerriero	GG	Nsg
[illegible]	[illegible]	NSG

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI E
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

0 0226
RA 0114

Patient's Personal Goal: For management of pain and fluid balance

Date	Problem Number	Identified Need/Problem	Goal / Outcome	Interventions	Initials	Date Resolved & Initials
5-19-04	#1	Pain related to (L) eye trauma	Report adequate rest, sleep and pain control	Provide pain meds as ordered	GG	
5-19-04	#2	Altered nutritional status due to vomiting	Pt will maintain fluid volume balance	Administer anti-emetics and IV fluids as per MD order and sips of clear fluids as tolerated	GG	
5/21	3	pre op → operation Anxiety	pt will have ↓anxiety comfort console	spend time discuss provide contact c̄ family	KG	5/22 KG

Date	Signature	Daily Prioritization	Interdisciplinary Team
5-20-04	[illegible]	1, 2	☐ MD ☑ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐
5/21	[illegible] RN	3, 1, 2	☐ MD ☑ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐
5/22	[illegible]	1, 2	☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐

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Know How Much We Care.

INTERDISCIPLINARY PATIENT EDUCATION RECORD

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001 191 350 ADM 05/19/2004

RA 0115

Education Barriers (that limit learning)
1. None
2. Level of Education
3. Culture/Religion
4. Language
5. Cognitive/Sensory
6. Motivation/Desire
7. Fatigue & Pain
8. Ethical
9. Finance
10. Physical Limitation
11. Other _____

Content Topic
1. Orientation to environment
2. Patient rights & responsibilities
3. Plan of Care
4. Pain Management
5. Discharge Planning
6. Activities/Daily Living
7. Procedural Care
8. Nutrition
9. Medications
10. Follow Up Care
11. Food & Drug Interactions
12. Physical Medicine Therapies
13. Medical Equipment/Supplies
14. Community Resources
15. Disease/Condition.
16. Other _____

Learner
1. Patient
2. Family
3. Responsible Care Giver
4. Forensic Staff
5. Significant other
6. Other _____

Teaching Method (Needs/Preferences)
1. Explanation
2. Written Material
3. Demonstration
4. Video
5. Role Playing
6. Physical Model
7. Group Interaction
8. Other _____

Evaluation
1. Verbalized Understanding
2. Demonstrated Understanding
3. Needs Reinforcement
4. No Evidence of Learning
5. Other _____

Discipline Codes Include:
RN Nursing
PT Physical Therapy
D Dietary
CM Case Mgmt
RT Respiratory
RAD Radiology
PH Pharmacy
ET Enterostomal
MD Physician
ST Speech Therapy
OT Occupational Therapy
SSP Spiritual Support Person
SW Social Worker
___ Other _____

DO NOT THIN THIS FORM

Comments to include intervention for barriers

Date	Education Barries	TOPIC	Learner	Teaching Methods	Evaluation	Signature	Discipline Code	Comments
5-19-04	1	1	1/2	2	1	G Guerrero	RN	
5-19-04	1	2	2	2	1	G Guerrero RT	RN	
5-19-04	1	4	1	1	1	G Guerrero	RN	
5-19-04	1	6	1	1	1	G Guerrero	RN	
5-19-04	1	5	1	1	1	G Guerrero	RN	
5/21	1	7	2	1	1	Kgatt	RN	
5/22	1	8	1/2	1	1	Brooks	RN	

ACCT: 0075603365

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INTERDISCIPLINARY PATIENT PLAN OF CARE

SIGNATURE	INT.	DISCIPLINE

0 0228

RA 0116

Patient's Personal Goal: ______________________

Date	Problem Number	Identified Need/Problem	Goal / Outcome	Interventions	Initials	Date Resolved & Initials

Date	Signature	Daily Prioritization	Interdisciplinary Team
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______
			☐ MD ☐ RN ☐ ET ☐ RAD ☐ RT ☐ D ☐ CM ☐ SW ☐ PT ☐ OT ☐ ST ☐ PH ☐ ______

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Care How Much We Know
Know How Much We Care

INTERDISCIPLINARY PATIENT EDUCATION RECORD

ACCT: 0075603365 DOB 09/22/1992
PATO, MAKANI K
LAZERSON, JACK
MR# 001-191-358
ADM 05/19/2004

0229
RA 0117

Education Barriers (that limit learning)
1. None
2. Level of Education
3. Culture/Religion
4. Language
5. Cognitive/Sensory
6. Motivation/Desire
7. Fatigue & Pain
8. Ethical
9. Finance
10. Physical Limitation
11. Other _____

Content Topic
1. Orientation to environment
2. Patient rights & responsibilities
3. Plan of Care
4. Pain Management
5. Discharge Planning
6. Activities/Daily Living
7. Procedural Care
8. Nutrition
9. Medications
10. Follow Up Care
11. Food & Drug Interactions
12. Physical Medicine Therapies
13. Medical Equipment/Supplies
14. Community Resources
15. Disease/Condition.
16. Other _____

Learner
1. Patient
2. Family
3. Responsible Care Giver
4. Forensic Staff
5. Significant other
6. Other _____

Teaching Method (Needs/Preferences)
1. Explanation
2. Written Material
3. Demonstration
4. Video
5. Role Playing
6. Physical Model
7. Group Interaction
8. Other _____

Evaluation
1. Verbalized Understanding
2. Demonstrated Understanding
3. Needs Reinforcement
4. No Evidence of Learning
5. Other _____

Discipline Code
RN Nursing
PT Physical Therapy
D Dietary
CM Case Mgmt
RT Respiratory
RAD Radiology
PH Pharmacy
ET Enterostomal
MD Physician
ST Speech Therapy
OT Occupational Therapy
SSP Spiritual Support Person
SW Social Worker
___ Other _____

DO NOT THIN THIS FORM

Comments to include intervention for barriers

Date	Education Barriers	TOPIC	Learner	Teaching Methods	Evaluation	Signature	Discipline Code	Comments

CODES: NC - NO CHANGE FROM PREVIOUS ASSESSMENT; W/N - WITHIN NORMAL ASSESSMENT; N/A - NOT APPLICABLE

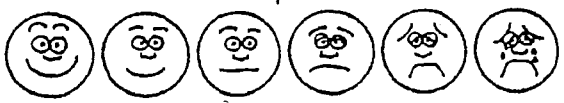
DATA BASE DATE: [redacted]/04 TIME: 16.00	TIME: [redacted]	TIME:	TIME:
SKIN AND MEMBRANES			
1. Skin Turgor: (Normal) / Tented / Tight Sec.	normal		
2. Skin Color: (Normal) / Pale / Cyanotic / Flushed / Mottled	normal		
3. Skin: (Warm) / Cool / (Dry) / Diaphoretic / Clammy	warm dry		
4. Skin Lesions: (None) / Bruising / Petechiae / Rash Describe:	nan		
5. Skin Integrity: (Intact) / Reddened / Breakdown / Decubitus Describe:	intact / reddened (L) sclera		
6. Mucous Membranes: (Moist) / Dry / Cracked / Lesions Describe:	MMM		
7. Mucous Membrane Color: (Normal) / Pale / Cyanotic	none		
8. Wound Location (L) eye abrasion; Steristrips / Sutures / Staples N/A Clean / Dry / Intact / Reddened / Approximated ~~N/A~~	(L) eye reddened		
9. Wound Drainage: Color N/A Drains: N/A Location N/A	0		
10. Peripheral Edema: None / Dependant / Pitting / (Peri-orbital) (L) eye Location: (L) eye Depth: N/A	(L) eye - peri orbital		
11. Additional Details: N/A	obs		
NEUROLOGICAL			
1. LOC: (Alert) / Lethargic / Responds to Pain / Irritable	alert		
2. Speech Pattern: (Clear) / Coos / Babble / Inappropriate for Age	clear		
3. Pupils: (PERRLA) / Nonreactive / Unequal (L) eye non-reactive	(R) PERRLA (L) sluggish		
4. Sensation/Pain: Tingling / Numbness / Dull / Sharp / Burning / (No Deficit) Location: (L) eye	N/A		
5. Cry: High Pitched / Hearty / Weak N/A	obs		
6. Fontanel: Soft / Flat / Bulging / Depressed N/A			
7. Additional Details: N/A			
CARDIO VASCULAR			
1. Capillary Refill: (Brisk) / Prolonged Sec: < 2 secs.	brisk < 2 sec		
2. Peripheral Pulse: (Strong) / Weak / Where Palpated: Radial, brachial	strong / radial		
3. Apical Pulse: (Strong) / Weak / (Regular) / Irregular / Murmur	strong / regular		
4. Peripheral Clubbing: Yes / (No)	no		
5. Additional Details N/A	obs		
RESPIRATORY			
1. Respiration: (Unlabored) / SOB / Grunting / Stridor / Nasal Flaring	unlabored		
2. Chest Excursion: (Symmetrical) / Asymmetrical / Retractions Type:	symmetrical		
3. Auscultation: (Clear) / Crackles / Wheezing / Diminished / Location:	clear		
4. Breath Patterns: (Eupnea) / Tachypnea / Bradypnea / Apnea	eupnea		
5. Cough: Productive / Nonproductive / (Absent) / Loose / Barky	0		
6. Sputum: Amount: N/A Color: N/A Consistency: N/A	0		
7. Tracheostomy: Type: N/A Size: N/A	0		
8. Nasal Discharge: Yes / (No) Describe: N/A	0		
9. Additional Details: N/A	obs		
GASTROINTESTINAL / ABDOMINAL			
1. Abdomen: (Soft) / Firm / Rigid / Distended / Tender	soft		
2. Bowel Sounds: (Normal) / Hyperactive / Hypoactive / Absent	normal		
3. N/G Tube: Patent / Clamped / Constant Suction / Intermittent Suction Describe Output: N/A	0		
4. N/G Feeding Tube: Enteral / Routine N/G / Gastrostomy: Tube / Button N/A	0		
5. Nutritional Feeding: clears	sips		
6. Abdominal Drain: N/A	0		
7. Stools: Color: no movement Consistency: Voluntary / Involuntary TBA.	TBA		
8. Additional Details: N/A	obs		
GENITOURINARY			
1. Voiding: (Continent) / Incontinent / Indwelling Catheter / Diapers	Enfant		
2. Urine: Color clear / yellow	clear yellow		
3. Urinary Bladder: (Not Palpable) / Distended	not palpable		
4. Genitalia: (Normal) / Abnormal / (Male) / Female	normal / uncircumcised		
5. Discharge: Site: N/A Describe: N/A	0		
6. Additional Details: N/A			
COGNOSOCIAL INTERACTION			
1. Affect: (Calm) / Irritable / Withdrawn / Angry / Smiling / Fearful	calm		
2. Family Visitation: (At Bedside) / Not Present / Called	mom present		
3. Additional Details: N/A			
DRESSING CHANGES			
1. Location of Dressing: N/A Type: N/A	N/A		
2. Location of Dressing: N/A Type: N/A			
3. Central Venous Device Dressing (every 72 hrs.): N/A			
4. Additional Comments: N/A			

SIGNATURE Sarah Shearer RN _____ _____ _____ _____

CO-SIGNATURE _____ _____ _____ _____ 0 0230

Pain Management

Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	0000	0100	0200	0300	0400	0500	0600
Pt Perception of Pain 0-10													7	6			0					0		
FLACC														0			0					0		
Location of pain													1	0			0					0		
Characteristics of pain													SHP/A	0			0					0		
Quality of pain													C	0			0					0		
Interventions													1	0			0					0		
Pt response to interventions 0-10														0			0					0		
Intervention required by MD														0			0					0		
Describe location of pain	1. (L) eye							2.									3.							
Describe intervention	1. MSO4							2.									3.							



Pain Legend

D-Dull
A-Aching
ST-Stabbing
SHP-Sharp
B-Burning
SHT-Shooting
PR-Prickly

Quality legend

C-Continuous
I/A-Intermittent with activity
I/s-Intermittent without activity

FLACC Assessment

ASSESS	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant, quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arches, rigid or jerking
CRY	No cry (Awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOL ABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

MODIFIED BRADEN Q SCALE — SKIN RISK ASSESSMENT TOOL

Intensity/Duration of Pressure	1	2	3	4	Score
Mobility	Completely limited	Very limited	Slightly limited	No limitations	4
Activity	Bedfast	Chair fast	Walks occasionally	Ambulatory	1
Sensory perception	Completely limited	Very limited	Slightly limited	No limitations	4
Moisture	Constantly moist	Very moist	Occasionally moist	Rarely moist	4
Shear/Friction	Significant problem	Problem	Potential problem	No apparent problem	4
Nutrition	Very poor	Inadequate	Adequate	Excellent	1
Tissue perfusion/oxygenation	Extremely compromised	Compromised	Adequate	Excellent	4

Final score 22
Order # Geomat Ordered
Initials JBS

Braden Scale

21-24 Static/Foam(lo risk)
18-21 Static/Foam (mod risk)
15-17 Low airloss/overlay (hi risk)
0-14 Specialized bed/air fluidized therapy when appropriate for age (hi risk)

0 0231

ROOM # 2107

DAILY PEDIATRIC NURSING FLOW RECORD
24 HOUR – DATA SUMMARY

UMC
UNIVERSITY MEDICAL CENTER
LAS VEGAS, NV
89102

SIGNATURES	
0700 - 1900	Sarah Shor
1900 - 0700	

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

DATE FROM 0700 5-19-04 TO 0700

ISOLATION: UNIVERSAL PRECAUTIONS / AFB / CONTACT / RESPIRATORY
CONTACT RSV / BODY FLUIDS / ENTERIC / STRICT

ALLERGIES:

SPECIMENS OBTAINED		TIME	INITIAL
1			
2			
3			
4			
5			
6			

X-RAYS / PROCEDURES COMPLETED		TIME
1		
2		
3		
4		

WEIGHTS

YESTERDAY'S WEIGHT _____ KG.

0700 - 1900	1900 - 0700
TIME:	TIME:
WEIGHT: ____ kg.	WEIGHT: ____ kg.
ABDOMINAL GIRTH ____ cm.	ABDOMINAL GIRTH ____ cm.
HEAD CIRCUMFERENCE ____ cm.	HEAD CIRCUMFERENCE ____ cm.

MEALS / SNACKS

BREAKFAST	LUNCH	DINNER
DIET:	DIET:	DIET:
% TAKEN:	% TAKEN:	% TAKEN:
SNACK	SNACK	SNACK
TIME:	TIME:	TIME:
WHAT:	WHAT:	WHAT:

FORMULA Clears

SUMMARY OF FLUIDS IN

	0700 - 1900	1900 - 0700	TOTALS
IV	700	1150	
PO	60	Sips	
NG			
G-TUBE			
TOTALS	760	1100	24° 1,860

SUMMARY OF FLUIDS OUT

	0700 - 1900	1900 - 0700	TOTALS
URINE	225	1140	
NG			
STOOL			
EMESIS			
TOTALS	225	1140	24° 1,365

HYGIENE

	0700 - 1900	1900 - 0700
AM / PM CARE		✓
ORAL CARE		✓
SKIN CARE		—
MEATAL / FOLEY CARE		
PERINEAL CARE		✓

ACTIVITY

ACTIVITY LEVEL:		BR/Amb
SIDERAILS		UP
HEAD OF BED:		

SAFETY

TYPE OF BED (circle) BED / CRIB / BASSINET / ISOLETTE

SAFETY RISK: LOW / MED / HIGH

VISITS

HEALTHCARE TEAM VISITS:	TIME	
PHYSICIAN		
RESIDENTS		
CONSULT:		
CONSULT:		
CONSULT:		
PATIENT ADVOCATE		
SOCIAL SERVICE		

0 0232

RA 0120

NEURO CHECK LEGEND

	INFANTS		CHILD / ADOLESCENT
EYE OPENING	SPONTANEOUS	4	SPONTANEOUS
	TO SPEECH	3	TO VOICE
	TO PAIN	2	TO PAIN
	NONE	1	NONE
VERBAL RESPONSE	COOS / BABBLES	5	ORIENTED
	IRRITABLE / CRIES	4	CONFUSED
	CRIES TO PAIN	3	INAPPROPRIATE WORDS
	MOANS TO PAIN	2	INCOMPREHENSIBLE WORDS
	NONE	1	NONE
MOTOR RESPONSE	NORMAL MOVEMENT	6	OBEYS COMMANDS
	WITHDRAWAL/TOUCH	5	LOCALIZES PAIN
	WITHDRAWAL/PAIN	4	WITHDRAWS
	ABNORMAL FLEXION	3	FLEXION
	ABNORMAL EXTENSION	2	EXTENSION
	NONE	1	NONE

PUPIL REACTIVITY
B - BRISK
S - SLUGGISH
N - NONREACTIVE

PUPIL SIZE
1 2 3 4 5 6 7 8

		07	08	09	10	11	12	13	14
	COMMENTS								
	TEMP.								
	PULSE								
	RESP.								
	B.P.								
NEURO ASSESSMENT	EYE OPENING								
	VERBAL RESPONSE								
	MOTOR RESPONSE								
	TOTAL								
	RIGHT PUPIL SIZE / REACTION								
	LEFT PUPIL SIZE / REACTION								
	CSM CHECKS 1.) 2.)								
I. V.'S	1. D5 ½ NS c̄ 20 meq KCl 100/°								
	2. NS								
	3.								
	SITE CHECKS 1.) (L) AC 2.)								
INTAKE	ORAL FLUIDS								
	NG / GT FLUSH								
	NG / GT FEEDINGS								
OUTPUT	URINE								
	EMESIS								
	NG / GT								
	STOOL								
MISC.	CAPILLARY BLOOD SUGAR/INSULIN								
	O_2 SATS								
	O_2 THERAPY								
	APNEA MONITOR								
	FAMILY INVOLVEMENT								

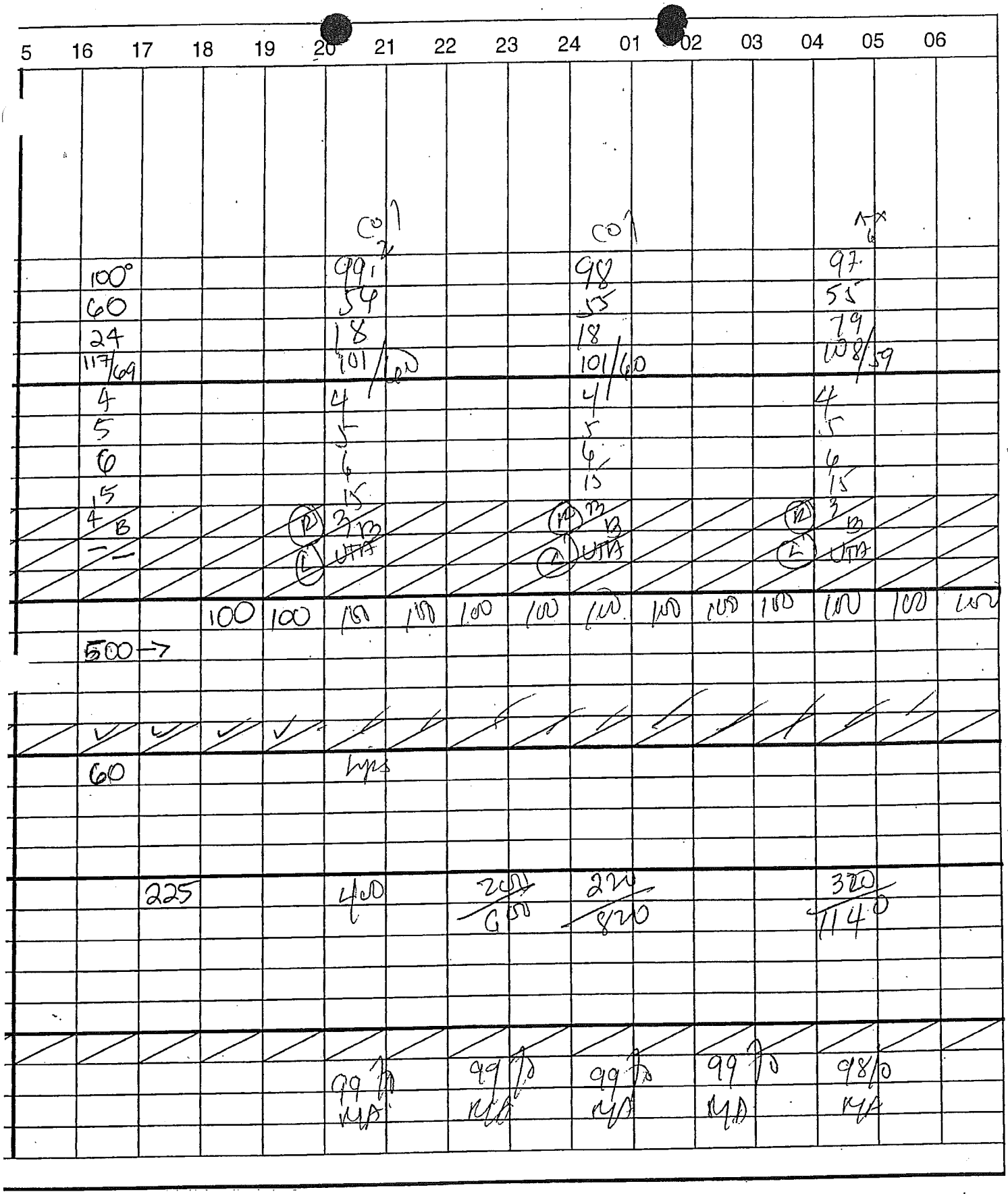
INTRAVENOUS START / RECORD

SIGNATURE			
COMMENTS			
D/C CANNULA			
ANTI-REFLUX LOCK			
DRESSING CHANGE			
N.S. FLUSH			
# ATTEMPTS			
CANNULA SIZE			
VEIN SITE			
RESTART			
IV START KIT			
TIME			

FAMILY INVOLVEMENT

MOM-MOTHER
DAD-FATHER
SIB-SIBLING
S/O-SIGNIFICANT OTHER
TCH-TEACHING DONE
ORT-ORIENTED

CALL-CALLED
VISIT-VISITED
HELD-HELD
FED-FED
BATH-BATHED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24
117/69
99
54
18
101/60
98
55
18
101/60
97
55
79
108/59
4
5
6
15
4
3
B
UTA
100
500
60
Lps
225
400
200
600
220
820
320
1140
99
98

LABEL

NURSING PROGRESS NOTES

DATE: 05/19/04 (EACH SHIFTS CHARTING WILL BEGIN WITH AN ASSESSMENT SUMMARY)

14:00 → Pt. admitted from E.R. room @ bedside. Pt. denies pain & is lying quietly in bed. — Tara B. Sheresa RN

18:00 → Pt. given pain medication as per M.D. order, resting comfortably in bed. NO Δ's in pt. status @ this time — Tara B. Sheresa RN

19 [illegible] Received [illegible]. Assumed care of pt. — [illegible]

(20[illegible]) Sleeping c dark glasses on. (L) eye - swollen. sclera reddened. [illegible] (L) AC patent - infusing D5 1/2 NS [illegible] 100 /hr site [illegible]. See initial assessment for further documentation. — [illegible]

(21[illegible]) awake, constant [illegible] (L) eye. No c/o pain. — [illegible]

(23[illegible]) watching TV c dark glasses on. No complaints verbalized. — [illegible]

(01[illegible]) Sleeping. Notified [illegible] of HR at 50's. No new orders given. Will continue to monitor. — [illegible]

(03[illegible]) Remains asleep. No S/S of distress — [illegible]

(05[illegible]) [illegible] NAD [illegible] site healthy. — [illegible]

(07[illegible]) Report given — [illegible]

0 0235

RA 0123

ROOM # 260

DAILY PEDIATRIC NURSING FLOW RECORD
24 HOUR – DATA SUMMARY

UMC UNIVERSITY MEDICAL CENTER
LAS VEGAS, NV 89102

SIGNATURES	
0700 - 1900	JBrownlee
1900 - 0700	

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

DATE FROM 0700 5-20-04 TO 0700 5-21-04

ISOLATION: UNIVERSAL PRECAUTIONS / AFB / CONTACT / RESPIRATORY CONTACT RSV / BODY FLUIDS / ENTERIC / STRICT

ALLERGIES: NKA

X-RAYS / PROCEDURES COMPLETED		TIME
1	CT Brain ± contrast	1245
2		
3		
4		

SPECIMENS OBTAINED		TIME	INITIAL
1			
2			
3			
4			
5			
6			

MEALS / SNACKS

BREAKFAST	LUNCH	DINNER
DIET: NPO	DIET: NPO	DIET: NPO
% TAKEN: 40%	% TAKEN: 10%	% TAKEN: 30%
SNACK	SNACK	SNACK
TIME:	TIME:	TIME:
WHAT:	WHAT:	WHAT:

FORMULA

WEIGHTS

YESTERDAY'S WEIGHT _____ KG.

0700 - 1900	1900 - 0700
TIME:	TIME:
WEIGHT: kg.	WEIGHT: kg.
ABDOMINAL GIRTH cm.	ABDOMINAL GIRTH cm.
HEAD CIRCUMFERENCE cm.	HEAD CIRCUMFERENCE cm.

SUMMARY OF FLUIDS IN

	0700 - 1900	1900 - 0700	TOTALS
IV	1200	1150	
PO	300	120	
NG	—		
G-TUBE	—		
TOTALS	1500	1270	24° 2,780

SUMMARY OF FLUIDS OUT

	0700 - 1900	1900 - 0700	TOTALS
URINE	925	750	
NG	—		
STOOL	—		
EMESIS	0		
TOTALS	925	750	24° 1,675

HYGIENE

	0700 - 1900	1900 - 0700
AM / PM CARE		as needed
ORAL CARE		
SKIN CARE		
MEATAL / FOLEY CARE		
PERINEAL CARE		

ACTIVITY

ACTIVITY LEVEL:		BR
SIDERAILS		UP
HEAD OF BED:		

TYPE OF BED (circle) (BED) / CRIB / BASSINET / ISOLETTE

SAFETY

SAFETY RISK: LOW / (MED) / HIGH

VISITS

HEALTHCARE TEAM VISITS:	TIME
PHYSICIAN	
RESIDENTS	
CONSULT:	
CONSULT:	
CONSULT:	
PATIENT ADVOCATE	
SOCIAL SERVICE	

0 0236

RA 0124

Pain Management

Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	0000	0100	0200	0300	0400	0500	0600
Pt Perception of Pain 0-10		4		4		0		0		4		0		0				0				0		
FLACC														0				0				0		
Location of pain		1								2				0				0				0		
Characteristics of pain														0				0				0		
Quality of pain														0				0				0		
Interventions				1						2		0		0				0				0		
Pt response to interventions 0-10					0									0				0				0		
Intervention required by MD														0				0				0		

Describe location of pain	1. H/A	2. Pain → ⓓ Eye	3.
Describe intervention	1. Tylenol Prn x2	2. MSO4 Prn x1	3.

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

Pain Legend

D-Dull
ST-Stabbing
B-Burning
PR-Prickly
A-Aching
SHP-Sharp
SHT-Shooting

Quality legend

C-Continuous
I/A-Intermittent with activity
I/S-Intermittent without activity

FLACC Assessment

ASSESS	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant, quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arches, rigid or jerking
CRY	No cry (Awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOL ABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

MODIFIED BRADEN Q SCALE — SKIN RISK ASSESSMENT TOOL

Intensity/Duration of Pressure	1	2	3	4	Score
Mobility	Completely limited	Very limited	Slightly limited	No limitations	4
Activity	Bedfast	Chair fast	Walks occasionally	Ambulatory	1
Sensory perception	Completely limited	Very limited	Slightly limited	No limitations	4
Moisture	Constantly moist	Very moist	Occasionally moist	Rarely moist	4
Shear/Friction	Significant problem	Problem	Potential problem	No apparent problem	4
Nutrition	Very poor	Inadequate	Adequate	Excellent	3
Tissue perfusion/oxygenation	Extremely compromised	Compromised	Adequate	Excellent	4

Final score 24

Order # 659 EMPE.

Initials JB.

Braden Scale

21-24 Static/Foam(lo risk)
18-21 Static/Foam (mod risk)
15-17 Low air loss/overlay (hi risk)
0-14 Specialized bed/air fluidized therapy when appropriate for age (hi risk)

CODES: NC - NO CHANGE FROM PREVIOUS ASSESSMENT; WN - WITHIN NORMAL ASSESSMENT; N/A - NOT APPLICABLE

DATA BASE	DATE: 5/20/04 TIME: 0840	TIME:	TIME:	TIME:
SKIN AND MEMBRANES	1. Skin Turgor: (Normal) / Tented / Tight Sec.	normal		
	2. Skin Color: (Normal) / Pale / Cyanotic / Flushed / Mottled	normal		
	3. Skin: (Warm) / Cool / (Dry) / Diaphoretic / Clammy	warm dry		
	4. Skin Lesions: (None) / Bruising / Petechiae / Rash Describe:	none		
	5. Skin Integrity: (Intact) / Reddened / Breakdown / Decubitus Describe:	intact (L) eye redness		
	6. Mucous Membranes: (Moist) / Dry / Cracked / Lesions Describe:	moist		
	7. Mucous Membrane Color: (Normal) / Pale / Cyanotic	normal		
	8. Wound Location: (L) (G) (T) Steristrips / Sutures / Staples Clean / Dry / Intact / Reddened / Approximated EDEMA	(L) eye		
	9. Wound Drainage: Color Sclera Reddened Drains: Location	0		
	10. Peripheral Edema: (None) / Dependant / Pitting (Peri-orbital) (L) Location: Depth:	(L) eye periorbital swelling		
	11. Additional Details: None	N/A		
NEUROLOGICAL	1. LOC: (Alert) / Lethargic / Responds to Pain / Irritable	alert		
	2. Speech Pattern: (Clear) / Coos / Babble / Inappropriate for Age	clear		
	3. Pupils: (PERRL) / Nonreactive / Unequal (L) Slightly Sluggish	PERRL		
	4. Sensation/Pain: Tingling / Numbness / Dull / Sharp / Burning / (No Deficit) Location:	No deficit		
	5. Cry: High Pitched / Hearty / Weak None	N/A		
	6. Fontanel: Soft / Flat / Bulging / Depressed None	N/A		
	7. Additional Details: None	N/A		
CARDIO VASCULAR	1. Capillary Refill: (Brisk) / Prolonged Sec: <3sec	brisk <3sec		
	2. Peripheral Pulses: (Strong) / Weak / Where Palpated: Radial/Pedal	strong radial/pedal		
	3. Apical Pulse: (Strong) / Weak / Regular / Irregular / Murmur	strong regular		
	4. Peripheral Clubbing: Yes / (No)	no		
	5. Additional Details None	N/A		
RESPIRATORY	1. Respiration: (Unlabored) / SOB / Grunting / Stridor / Nasal Flaring	unlabored		
	2. Chest Excursion: (Symmetrical) / Asymmetrical / Retractions Type:	symmetrical		
	3. Auscultation: (Clear) / Crackles / Wheezing / Diminished / Location:	clear		
	4. Breath Patterns: (Eupnea) / Tachypnea / Bradypnea / Apnea	eupnea		
	5. Cough: Productive / Nonproductive / (Absent) / Loose / Barky	0		
	6. Sputum: Amount: N/A Color: Consistency:	0		
	7. Tracheostomy: Type: N/A Size:	0		
	8. Nasal Discharge: Yes / (No) Describe:	0		
	9. Additional Details: None	N/A		
GASTROINTESTINAL / ABDOMINAL	1. Abdomen: (Soft) / Firm / Rigid / Distended / Tender	soft		
	2. Bowel Sounds: (Normal) / Hyperactive / Hypoactive / Absent	normal		
	3. N/G Tube: Patent / Clamped / Constant Suction / Intermittent Suction Describe Output: N/A	0		
	4. N/G Feeding Tube: Enteral / Routine N/G / Gastrostomy: Tube / Button N/A	0		
	5. Nutritional Feeding: Regular	regular		
	6. Abdominal Drain: None	0		
	7. Stools: Color: BA yellow brown Consistency: Loose, soft (Voluntary) / Involuntary	BM		
	8. Additional Details: None	N/A		
GENITOURINARY	1. Voiding: (Continent) / Incontinent / Indwelling Catheter / Diapers	continent		
	2. Urine: Color Yellow	yellow		
	3. Urinary Bladder: (Not Palpable) / Distended	not palpable		
	4. Genitalia: Normal / Abnormal / Male / Female circumcised	WNL		
	5. Discharge: Site: circumcised Describe:	N/A		
	6. Additional Details: None	N/A		
COPING/SOCIAL INTERACTION	1. Affect: (Calm) / Irritable / Withdrawn / Angry / Smiling / Fearful	calm		
	2. Family Visitation: At Bedside / Not Present / Called GPA	not present		
	3. Additional Details: None	N/A		
DRESSING CHANGES	1. Location of Dressing: N/A Type:	N/A		
	2. Location of Dressing: N/A Type:			
	3. Central Venous Device Dressing (every 72 hrs.): N/A			
	4. Additional Comments None			

SIGNATURE

CO-SIGNATURE

0 0238

RA 0126

NEURO CHECK LEGEND

Category	Infants	Score	Child / Adolescent
EYE OPENING	SPONTANEOUS	4	SPONTANEOUS
	TO SPEECH	3	TO VOICE
	TO PAIN	2	TO PAIN
	NONE	1	NONE
VERBAL RESPONSE	COOS / BABBLES	5	ORIENTED
	IRRITABLE / CRIES	4	CONFUSED
	CRIES TO PAIN	3	INAPPROPRIATE WORDS
	MOANS TO PAIN	2	INCOMPREHENSIBLE WORDS
	NONE	1	NONE
MOTOR RESPONSE	NORMAL MOVEMENT	6	OBEYS COMMANDS
	WITHDRAWAL/TOUCH	5	LOCALIZES PAIN
	WITHDRAWAL/PAIN	4	WITHDRAWS
	ABNORMAL FLEXION	3	FLEXION
	ABNORMAL EXTENSION	2	EXTENSION
	NONE	1	NONE

PUPIL REACTIVITY

B - BRISK
S - SLUGGISH
N - NONREACTIVE

PUPIL SIZE

1 2 3 4 5 6 7 8

		07	08	09	10	11	12	13	14
	COMMENTS		101				1245 CT Brain [illegible] done 101		
	TEMP.		99.8				98.9		
	PULSE		68				80		
	RESP.		16				16		
	B.P.		99/65				[illegible]/55		
NEURO ASSESSMENT	EYE OPENING		4				4		
	VERBAL RESPONSE		5				5		
	MOTOR RESPONSE		6				6		
	TOTAL		15				15		
	RIGHT PUPIL SIZE / REACTION		4 / B				4 / B		
	LEFT PUPIL SIZE / REACTION		4 / S				4 / S		
	CSM CHECKS 1.) 2.)								
I. V. 'S	1. D5 ½ 2S 20K	100	100	100	100	100	100	100	100
	2.								
	3.								
	SITE CHECKS 1.) (L) A/C 2.)	✓	✓	✓	✓	✓	✓	✓	✓
INTAKE	ORAL FLUIDS		120				120		
	NG / GT FLUSH		N/A				N/A		
	NG / GT FEEDINGS		N/A				N/A		
OUTPUT	URINE		350				275		150
	EMESIS		0				0		
	NG / GT		N/A				N/A		
	STOOL		0				0		✓
MISC.	CAPILLARY BLOOD SUGAR/INSULIN		N/A				N/A		
	O_2 SATS		98				99		
	O_2 THERAPY		R/A				R/A		
	APNEA MONITOR		N/A				N/A		
	FAMILY INVOLVEMENT		Gd PA				0	1245 mother [illegible]	

INTRAVENOUS START / RECORD

TIME	IV START KIT	RESTART	VEIN SITE	CANNULA SIZE	# ATTEMPTS	N.S. FLUSH	DRESSING CHANGE	ANTI-REFLUX LOCK	CANNULA D/C	COMMENTS	SIGNATURE

FAMILY INVOLVEMENT

MOM-MOTHER
DAD-FATHER
SIB-SIBLING
S/O-SIGNIFICANT OTHER
TCH-TEACHING DONE
ORT-ORIENTED

CALL-CALLED
VISIT-VISITED
HELD-HELD
FED-FED
BATH-BATHED

0 0239

RA 0127

15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
	(0)														
	99				98.7				98.9				97.8		
	24				62				64.1				65		
	16				18				20				18		
	98/63				96/59				111/56				112/56		
	4				4				4				4		
	5				5				5				5		
	6				6				6				6		
	15				15				15				15		
	4B				3B				3B				3B		
	4S				3D				3B				3B		
150	100	100	100	NV	NV	NV	NV	NV	NV	NV	NV	NV	NV	NV	NV
	Ø	120				120			NPO						
	NA														
	NA														
	150				250		100			200			200		
	Ø						350			550			750		
	NA														
	Ø														
	~~NA~~														
	99				99 70		99 70		99 70		98 70		99 70		
	NA				NA		NA		NA		NA		NPO		
	NA														
	GDPA														

LABEL

0 0240

RA 0128

NURSING PROGRESS NOTES

DATE: 5/20/04

(EACH SHIFTS CHARTING WILL BEGIN WITH AN ASSESSMENT SUMMARY)

0800 Resting in Bed Awake — Grandfather @ Bedside Diet Completed 40% & Tol. Wearing Sunglasses CC [illegible] H/A - IV Infusing well Site s Redness Edema or Tenderness SAT O2 HOB↑ Bedrest Status Brown

1000 Resting Quietly in Bed — [illegible] Giving [illegible] for H/A + [illegible]. IV 500 D5½S Going well & [illegible] Pox 99% O2 Sat - Brown

1200 Resting Quietly H/A relieved Brown

1220 → Trauma CT for CT Brain s contrast Brown

1240 CT Done mom Present c Sibling Returned to room Post CT [illegible] Brown

1400 OOB → BR - BR x1 Returned to Bed. HOB↑ SAT WATching TV TAlking on Phone IV Site s Redness Edema or Tenderness to TOUCH Brown

1600 GdPA @ Bedside - Attempted to Contact mom @ Home re: OR consents H/M c Aunt. Child Resting HOB↑. Pox - Maintained IV Infusing well Vol/amber [illegible] Brown

1800 [illegible] HOB↑ IV Continues — No [illegible] s [illegible] Spoke c Mom this Afternoon 7/OVS this PM will Sign Consents for OR Brown

1915 Received rpt - assumed care of pt. - [illegible]

2000 Sleeping. No apparent sign of discomfort or pain. VSS. afebrile. [illegible]

cont. patent infusing D5½NS c 20 meq KCl at 100/hr. site unremarkable. See initial assessment for further documentation.

2200 Instructed pt. NPO p MN. Pt verbalized understanding. Settled for sleep.

2300 Sleeping s distress.

0100 Remains asleep. Kept NPO p MN - s distress

0300 Sleeping. Resp. easy/even

0500 Condition stable. No c/o pain. Assessment unchanged. IVF infusing well site [illegible]

0700 Report given - [illegible]

0 0241

ROOM # 2001

DAILY PEDIATRIC NURSING FLOW RECORD
24 HOUR – DATA SUMMARY

UMC UNIVERSITY MEDICAL CENTER
LAS VEGAS, NV 89102

ACCT: 007603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

DATE FROM 0700 5-21-04 TO 0700 5-22-04

SIGNATURES	
0700 - 1900	
1900 - 0700	

ISOLATION: UNIVERSAL PRECAUTIONS / AFB / CONTACT / RESPIRATORY CONTACT RSV / BODY FLUIDS / ENTERIC / STRICT

ALLERGIES: NKA

SPECIMENS OBTAINED	TIME	INITIAL
1		
2		
3		
4		
5		
6		

X-RAYS / PROCEDURES COMPLETED	TIME
1	
2	
3	
4	

WEIGHTS

YESTERDAY'S WEIGHT _____ KG.

0700 - 1900	1900 - 0700
TIME:	TIME:
WEIGHT: kg.	WEIGHT: kg.
ABDOMINAL GIRTH cm.	ABDOMINAL GIRTH cm.
HEAD CIRCUMFERENCE cm.	HEAD CIRCUMFERENCE cm.

MEALS / SNACKS

BREAKFAST	LUNCH	DINNER
DIET: LPO	DIET: LPO	DIET: PDG
% TAKEN:	% TAKEN:	% TAKEN:
SNACK	SNACK	SNACK
TIME:	TIME:	TIME:
WHAT:	WHAT:	WHAT:

FORMULA

SUMMARY OF FLUIDS IN

	0700 - 1900	1900 - 0700	TOTALS
IV	80	120	
PO		240	
NG			
G-TUBE			
TOTALS	80	1440	24° 2240

SUMMARY OF FLUIDS OUT

	0700 - 1900	1900 - 0700	TOTALS
URINE	700	1250	
NG			
STOOL		0	
EMESIS		0	
TOTALS	700	1250	24° 1950

		0700 - 1900	1900 - 0700
HYGIENE	AM / PM CARE		
	ORAL CARE		
	SKIN CARE		
	MEATAL / FOLEY CARE		
	PERINEAL CARE		
ACTIVITY	ACTIVITY LEVEL:	ad lib	BR
	SIDERAILS	UP	UP
	HEAD OF BED:	30°	flat
SAFETY	TYPE OF BED (circle) BED / CRIB / BASSINET / ISOLETTE		
	SAFETY RISK LOW / MED / HIGH		

VISITS	HEALTHCARE TEAM VISITS:	TIME
	PHYSICIAN	
	RESIDENTS	
	CONSULT:	
	CONSULT:	
	CONSULT:	
	PATIENT ADVOCATE	
	SOCIAL SERVICE	0242

Pain Management

Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	0000	0100	0200	0300	0400	0500	0600
Pt Perception of Pain 0-10		3	6				Ø			Ø			6				4					0		
FLACC																								
Location of pain			Back										Lt leg				Lt leg							
Characteristics of pain													A				A							
Quality of pain													C				C							
Interventions			Med.										1				2							
Pt response to interventions 0-10														8				10						
Intervention required by MD													N				N							
Describe location of pain	1. H/A								2. l. eye								3.							
Describe intervention	1. MS								2. tylenol.								3.							

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

Pain Legend

D-Dull
A-Aching
ST-Stabbing
SHP-Sharp
B-Burning
SHT-Shooting
PR-Prickly

Quality legend

C-Continuous
I/A-Intermittent with activity
I/s-Intermittent without activity

FLACC Assessment

ASSESS	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant, quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arches, rigid or jerking
CRY	No cry (Awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOL ABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

MODIFIED BRADEN Q SCALE — SKIN RISK ASSESSMENT TOOL

Intensity/Duration of Pressure	1	2	3	4	Score
Mobility	Completely limited	Very limited	Slightly limited	No limitations	
Activity	Bedfast	Chair fast	Walks occasionally	Ambulatory	
Sensory perception	Completely limited	Very limited	Slightly limited	No limitations	
Moisture	Constantly moist	Very moist	Occasionally moist	Rarely moist	
Shear/Friction	Significant problem	Problem	Potential problem	No apparent problem	
Nutrition	Very poor	Inadequate	Adequate	Excellent	
Tissue perfusion/oxygenation	Extremely compromised	Compromised	Adequate	Excellent	

Final score 27

Order # _____

Initials PG

Braden Scale

21-24 Static/Foam(lo risk)
18-21 Static/Foam (mod risk)
15-17 Low airloss/overlay (hi risk)
0-14 Specialized bed/air fluidized therapy when appropriate for age (hi risk)

CODES: NC - NO CHANGE FROM PREVIOUS ASSESSMENT; W/N - WITHIN NORMAL ASSESSMENT; N/A - NOT APPLICABLE

	DATA BASE DATE: 5/6/09 TIME:	TIME:	TIME:	TIME:
SKIN AND MEMBRANES	1. Skin Turgor: Normal / Tented / Tight Sec	nl		
	2. Skin Color: Normal / Pale / Cyanotic / Flushed / Mottled	nl		
	3. Skin: Warm / Cool / Dry / Diaphoretic / Clammy	wd		
	4. Skin Lesions: None / Bruising / Petechiae / Rash Describe:	none		
	5. Skin Integrity: Intact / Reddened / Breakdown / Decubitus Describe:	intact		
	6. Mucous Membranes: Moist / Dry / Cracked / Lesions Describe:	moist		
	7. Mucous Membrane Color: Normal / Pale / Cyanotic	nl		
	8. Wound Location: Steristrips / Sutures / Staples Clean / Dry / Intact / Reddened / Approximated	o		
	9. Wound Drainage: Color Drains: Location	o		
	10. Peripheral Edema: None / Dependant / Pitting / Peri-orbital Location: Depth:	none		
	11. Additional Details:			
NEUROLOGICAL	1. LOC: Alert / Lethargic / Responds to Pain / Irritable	alert		
	2. Speech Pattern: Clear / Coos / Babble / Inappropriate for Age	clear		
	3. Pupils: PERRLA / Nonreactive / Unequal Eye closure	PERRLA		
	4. Sensation/Pain: Tingling / Numbness / Dull / Sharp / Burning / No Deficit Location:	Achy HA l-eye		
	5. Cry: High Pitched / Hearty / Weak	nl		
	6. Fontanel: Soft / Flat / Bulging / Depressed	NT		
	7. Additional Details:	patch+shield to l. eye		
CARDIO VASCULAR	1. Capillary Refill: Brisk / Prolonged Sec:	Brisk <2sec		
	2. Peripheral Pulse: Strong / Weak / Where Palpated:	Strong Rad/Radial		
	3. Apical Pulse: Strong / Weak / Regular / Irregular / Murmur	Strong Reg		
	4. Peripheral Clubbing: Yes / No	no		
	5. Additional Details			
RESPIRATORY	1. Respiration: Unlabored / SOB / Grunting / Stridor / Nasal Flaring	unlabored		
	2. Chest Excursion: Symmetrical / Asymmetrical / Retractions Type:	symm		
	3. Auscultation: Clear / Crackles / Wheezing / Diminished / Location:	clear		
	4. Breath Patterns: Eupnea / Tachypnea / Bradypnea / Apnea	eupnea		
	5. Cough: Productive / Nonproductive / Absent / Loose / Barky	absent		
	6. Sputum: Amount: Color: Consistency:	o		
	7. Tracheostomy: Type: Size:	o		
	8. Nasal Discharge: Yes / No Describe: clear runny.	NO		
	9. Additional Details:			
GASTROINTESTINAL / ABDOMINAL	1. Abdomen: Soft / Firm / Rigid / Distended / Tender	Soft NT		
	2. Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent	NB		
	3. N/G Tube: Patent / Clamped / Constant Suction / Intermittent Suction Describe Output:	o		
	4. N/G Feeding Tube: Enteral / Routine N/G / Gastrostomy: Tube / Button	o		
	5. Nutritional Feeding: NPO	Reg.		
	6. Abdominal Drain:	o		
	7. Stools: Color: Consistency: Voluntary / Involuntary	BS		
	8. Additional Details:			
GENITOURINARY	1. Voiding: Continent / Incontinent / Indwelling Catheter / Diapers	Cont		
	2. Urine: Color Yellow.	yell.		
	3. Urinary Bladder: Not Palpable / Distended	not palp		
	4. Genitalia: Normal / Abnormal / Male / Female	male		
	5. Discharge: Site: Describe:	o		
	6. Additional Details:			
PSYCHOSOCIAL INTERACTION	1. Affect: Calm / Irritable / Withdrawn / Angry / Smiling / Fearful	calm		
	2. Family Visitation: At Bedside / Not Present / Called	Late present		
	3. Additional Details:			
DRESSING CHANGES	1. Location of Dressing: Type:	patch+shield l. eye		
	2. Location of Dressing: Type:			
	3. Central Venous Device Dressing (every 72 hrs.):			
	4. Additional Comments:	L SC - NL		

SIGNATURE _____ _____ _____ _____

CO-SIGNATURE _____ _____ _____ _____

NEURO CHECK LEGEND

	INFANTS		VERBAL RESPONSE		MOTOR RESPONSE	
4	SPONTANEOUS	5	COOS / BABBLES	6	NORMAL MOVEMENT	
3	TO SPEECH	4	IRRITABLE / CRIES	5	WITHDRAWAL/TOUCH	
2	TO PAIN	3	CRIES TO PAIN	4	WITHDRAWAL/PAIN	
1	NONE	2	MOANS TO PAIN	3	ABNORMAL FLEXION	
		1	NONE	2	ABNORMAL EXTENSION	
				1	NONE	

CHILD / ADOLESCENT	EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
SPONTANEOUS		ORIENTED	OBEYS COMMANDS
TO VOICE		CONFUSED	LOCALIZES PAIN
TO PAIN		INAPPROPRIATE WORDS	WITHDRAWS
NONE		INCOMPREHENSIBLE WORDS	FLEXION
		NONE	EXTENSION
			NONE

PUPIL REACTIVITY
B - BRISK
S - SLUGGISH
N - NONREACTIVE

PUPIL SIZE
1 2 3 4
5 6 7 8

		07	08	09	10	11	12	13	14	1
	COMMENTS									
	TEMP.		99					98		
	PULSE		73					103		
	RESP.		18					18		
	B.P.		92/52					122/69		
NEURO ASSESSMENT	EYE OPENING		4					3		
	VERBAL RESPONSE		5					5		
	MOTOR RESPONSE		6					6		
	TOTAL		15					15		
	RIGHT PUPIL SIZE		2							
	RIGHT PUPIL REACTION		BR							
	LEFT PUPIL SIZE									
	LEFT PUPIL REACTION		BR							
	CSM CHECKS 1.) 2.)									
I. V. 'S	1. D5 1/2 NS @ 70K.	100	100	150	— DC —				100	
	2.									
	3.									
	SITE CHECKS 1.) DRY 2.)	✓	✓	✓					✓	
INTAKE	ORAL FLUIDS	NPO	NPO							
	NG / GT FLUSH									
	NG / GT FEEDINGS									
OUTPUT	URINE		140	80					280	
	EMESIS									
	NG / GT									
	STOOL									
MISC.	CAPILLARY BLOOD SUGAR/INSULIN									
	O_2 SATS		99%					98%		
	O_2 THERAPY		RA					RA		
	APNEA MONITOR									
	FAMILY INVOLVEMENT									

INTRAVENOUS START / RECORD

TIME	IV START KIT	RESTART	VEIN SITE	CANNULA SIZE	# ATTEMPTS	N.S. FLUSH	DRESSING CHANGE	ANTI-REFLUX LOCK	CANNULA D/C	COMMENTS	SIGNATURE

FAMILY INVOLVEMENT

MOM-MOTHER
DAD-FATHER
SIB-SIBLING
S/O-SIGNIFICANT OTHER
TCH-TEACHING DONE
ORT-ORIENTED

CALL-CALLED
VISIT-VISITED
HELD-HELD
FED-FED
BATH-BATHED

0 0245

RA 0133

	5	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
						2040 MS for HA			Tylenol given HA							
		98%				98%				97%				96% AX		
		84				72				68				63		
		18				20				20				22		
		90/50				102/51				105/56				102/56		
		3				4 R eye				4 L eye c patch + shield				4		
		5				5				5				5		
		6				6				6				6		
		15				15				15				15		
						3B				3B				3B		
		closed				closed c shield										
						WNL				WNL				WNL		
	100	100	100	100	1w	1w	1w	1w	1w	1w	1w	1w	1w	1w	1w	1w
	✓	✓	✓	✓	LAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
						120				120/240						
		200			400				350/750		200/950			300/1250		
		98%			97%	98	98	99	98	98	98	98	98	98	99	98
		RA			RA											

LABEL

0 0246

NURSING PROGRESS NOTES

DATE: (EACH SHIFTS CHARTING WILL BEGIN WITH AN ASSESSMENT SUMMARY)

0800 pt laying in bed HOBT 45°
pt c sunglasses on, VSS, afebrile
O2 sat 99% RA, PIV (L) AC infusing
D5 1/2 20K @ 100/hr ∅ s/s
infiltration (L) eye swollen, red
clear discharge/teary, pt able to
open on own only slightly
pt states mom is coming before pt
to OR, pt verbalizes understanding
NPO Kaupgat

0830 pt c/o pain (L) eye, using face scale
5/10, pt received 2mg MSO4 IV per MD
order Kaupgat

900 pt (+) relief pain c MSO4, grandfather
c pt Kaupgat

1230 pt returned from OR - irrigation
(L) eye, pt sleepy - arousable
VSS, O2 sat 98% RA - parents
at bedside, pt c eyeshield
over (L) eye, (L) AC PIV ∅ s/s
infiltration, will f/u c postop
orders c peds resident
Kaupgat

1400 pt awake - denies pain, (+) void
Kaupgat

1600 pt c (L) eye patch-shield ∅ drainage
pt c c/o pain, HOBT, PIV infusing
per MD order - order Reg diet for dinner.
MD advised keep eyeshield on until
tomorrow will start eye gtts.
VSS afebrile Kaupgat

1800 pt denies pain, pt c (L) eye shield
in place - pt eating dinner
HOBT, ∅ c/o headache, ∅ emesis
pt states he feels better after sugar Kgat

1900 spoke c MD re: Continue Diamox
resident will f/u c opthamologist
and call RN back Kgat

2000 (L) Stalle. watching TV.
2040 c/o H/A + l. eye pain
MS given
2100 Resting
quietly. still c slight H/A
2300 watching TV - Tylenol given
for c/o H/A
0100 asleep
0300 asleep - HOBT. eye shield
on.
0430 asleep
Ustalle.
0600 Remains
asleep

0 0247

ROOM # 5[illegible]

DAILY PEDIATRIC NURSING FLOW RECORD
24 HOUR – DATA SUMMARY

UMC
UNIVERSITY MEDICAL CENTER
LAS VEGAS, NV
89102

SIGNATURES

0700 - 1900 [signature]

1900 - 0700 [signature]

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

DATE FROM 0700 5/22/14 TO 0700 5/23

ISOLATION: UNIVERSAL PRECAUTIONS / AFB / CONTACT / RESPIRATORY
CONTACT RSV / BODY FLUIDS / ENTERIC / STRICT

ALLERGIES: NKA

SPECIMENS OBTAINED		TIME	INITIAL
1			
2			
3			
4			
5			
6			

X-RAYS / PROCEDURES COMPLETED		TIME
1		
2		
3		
4		

WEIGHTS

YESTERDAY'S WEIGHT _____ KG.

0700 - 1900	1900 - 0700
TIME:	TIME:
WEIGHT: _____ kg.	WEIGHT: _____ kg.
ABDOMINAL GIRTH _____ cm.	ABDOMINAL GIRTH _____ cm.
HEAD CIRCUMFERENCE _____ cm.	HEAD CIRCUMFERENCE _____ cm.

MEALS / SNACKS

BREAKFAST	LUNCH	DINNER
DIET: Reg	DIET: Reg	DIET: Reg
% TAKEN: 75%	% TAKEN: 80	% TAKEN: 60%
SNACK	SNACK	SNACK
TIME:	TIME:	TIME:
WHAT:	WHAT:	WHAT:

FORMULA Reg

SUMMARY OF FLUIDS IN		0700 - 1900	1900 - 0700	TOTALS
	IV	1200	1200	
	PO	360		
	NG	-		
	G-TUBE	-		
	TOTALS	1560		24°

SUMMARY OF FLUIDS OUT		0700 - 1900	1900 - 0700	TOTALS
	URINE	900	1475	
	NG	0		
	STOOL	0	0	
	EMESIS	0	0	
	TOTALS	900	1475	24° 2375

HYGIENE	0700 - 1900	1900 - 0700
AM / PM CARE		
ORAL CARE		
SKIN CARE		
MEATAL / FOLEY CARE		
PERINEAL CARE		
ACTIVITY LEVEL:		BRP
SIDERAILS		↑↑
HEAD OF BED:		4

TYPE OF BED (circle) BED / CRIB / BASSINET / ISOLETTE

SAFETY RISK: LOW / MED / HIGH

VISITS	HEALTHCARE TEAM VISITS:	TIME
	PHYSICIAN	
	RESIDENTS	
	CONSULT:	
	CONSULT:	
	CONSULT:	
	PATIENT ADVOCATE	
	SOCIAL SERVICE	

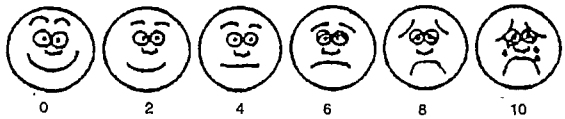
0 0248

RA 0136

Pain Management

Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	0000	0100	0200	0300	0400	0500	0600
Pt Perception of Pain 0-10	4/10				0		0		0					4				0				0		
FLACC																								
Location of pain	1													1										
Characteristics of pain														A										
Quality of pain														C										
Interventions	1				0		0		0					1										
Pt response to interventions 0-10			4/10												10									
Intervention required by MD														N										

Describe location of pain	1. (L) Eye	2.	3.
Describe intervention	1. Tylenol Tab PO	2.	3.



Pain Legend

D-Dull
ST-Stabbing
B-Burning
PR-Prickly
A-Aching
SHP-Sharp
SHT-Shooting

Quality legend

C-Continuous
I/A-Intermittent with activity
I/S-Intermittent without activity

FLACC Assessment

ASSESS	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant, quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arches, rigid or jerking
CRY	No cry (Awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOL ABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

MODIFIED BRADEN Q SCALE — SKIN RISK ASSESSMENT TOOL

Intensity/Duration of Pressure	1	2	3	4	Score
Mobility	Completely limited	Very limited	Slightly limited	No limitations	4
Activity	Bedfast	Chair fast	Walks occasionally	Ambulatory	3/1
Sensory perception	Completely limited	Very limited	Slightly limited	No limitations	4
Moisture	Constantly moist	Very moist	Occasionally moist	Rarely moist	4
Shear/Friction	Significant problem	Problem	Potential problem	No apparent problem	4
Nutrition	Very poor	Inadequate	Adequate	Excellent	3
Tissue perfusion/oxygenation	Extremely compromised	Compromised	Adequate	Excellent	4

Final score _____

Order # _____

Initials _____

Braden Scale

21-24 Static/Foam(lo risk)
18-21 Static/Foam (mod risk)
15-17 Low airloss/overlay (hi risk)
0-14 Specialized bed/air fluidized therapy when appropriate for age (hi risk)

CODES: NC - NO CHANGE FROM PREVIOUS ASSESSMENT; W/N - WITHIN NORMAL ASSESSMENT; N/A - NOT APPLICABLE

	DATA BASE DATE: [redacted]2/04 TIME: 0915	TIME: [redacted]	TIME:	TIME:
SKIN AND MEMBRANES	1. Skin Turgor: (Normal) / Tented / Tight Sec.	nl		
	2. Skin Color: (Normal) / Pale / Cyanotic / Flushed / Mottled	nl		
	3. Skin: (Warm) / Cool / (Dry) / Diaphoretic / Clammy	W/D		
	4. Skin Lesions: (None) / Bruising / Petechiae / Rash Describe:	none		
	5. Skin Integrity: (Intact) / Reddened / Breakdown / Decubitus Describe:	intact		
	6. Mucous Membranes: (Moist) / Dry / Cracked / Lesions Describe:	moist		
	7. Mucous Membrane (Color-Normal) / Pale / Cyanotic	nl.		
	8. Wound Location: (L) eye Steristrips / Sutures / Staples Clean / Dry / Intact / Reddened / Approximated c̄ Pad + Shield	(L) eye c̄ shield.		
	9. Wound Drainage: Color Drains: Ø Location	Ø		
	10. Peripheral Edema: (None) / Dependant / Pitting / Peri-orbital Location: Depth:	none		
	11. Additional Details: None			
NEUROLOGICAL	1. LOC: (Alert) / Lethargic / Responds to Pain / Irritable	alert		
	2. Speech Pattern: (Clear) / Coos / Babble / Inappropriate for Age	clear.		
	3. Pupils: (PERRLA) / Nonreactive / Unequal R pupil Eval only reactive	PERRLA - R eye only - reactive		
	4. Sensation/Pain: Tingling / Numbness / Dull / Sharp / Burning / (No Deficit) Location:	Achy eye		
	5. Cry: High Pitched / Hearty / Weak N/A	NA		
	6. Fontannel: Soft / Flat / Bulging / Depressed N/A (closed)	NA		
	7. Additional Details: None			
CARDIO VASCULAR	1. Capillary Refill: (Brisk) / Prolonged Sec: < 3 sec	Brisk < 2 sec		
	2. Peripheral Pulse: (Strong) / Weak / Where Palpated: Radial / Pedal	Strong Rad / Pedal		
	3. Apical Pulse: (Strong) / Weak / Regular / Irregular / Murmur	Strong Reg		
	4. Peripheral Clubbing: Yes / (No)	NO		
	5. Additional Details None			
RESPIRATORY	1. Respiration: (Unlabored) / SOB / Grunting / Stridor / Nasal Flaring	unlabored		
	2. Chest Excursion: (Symmetrical) / Asymmetrical / Retractions Type:	Symm		
	3. Auscultation: (Clear) / Crackles / Wheezing / Diminished / Location:	Clear		
	4. Breath Patterns: (Eupnea) / Tachypnea / Bradypnea / Apnea	eupnea.		
	5. Cough: Productive / Nonproductive / (Absent) / Loose / Barky	absent		
	6. Sputum: Amount N/A Color: Consistency:	Ø		
	7. Tracheostomy: Type: N/A Size:	Ø		
	8. Nasal Discharge: Yes / (No) Describe:	NO		
	9. Additional Details: None			
GASTROINTESTINAL / ABDOMINAL	1. Abdomen: (Soft) / Firm / Rigid / Distended / Tender	Soft		
	2. Bowel Sounds: (Normal) / Hyperactive / Hypoactive / Absent	nl.		
	3. N/G Tube: Patent / Clamped / Constant Suction / Intermittent Suction Describe Output: N/A	Ø		
	4. N/G Feeding Tube: Enteral / Routine N/G / Gastrostomy: Tube / Button N/A	Ø		
	5. Nutritional Feeding: Reg	Reg.		
	6. Abdominal Drain: N/A	Ø		
	7. Stools: Color TBA Consistency: (Voluntary) / Involuntary	TBA		
	8. Additional Details: None			
GENITOURINARY	1. Voiding: (Continent) / Incontinent / Indwelling Catheter / Diapers	Cont.		
	2. Urine: Color yellow	yell.		
	3. Urinary Bladder: (Not Palpable) / Distended	not palp.		
	4. Genitalia: Normal / Abnormal / Male / Female deferred	male		
	5. Discharge: Site: deferred Describe:	Ø		
	6. Additional Details: None			
COPING/SOCIAL INTERACTION	1. Affect: (Calm) / Irritable / Withdrawn / Angry / Smiling / Fearful	calm		
	2. Family Visitation: At Bedside / (Not Present) / Called	not present		
	3. Additional Details: None			
DRESSING CHANGES	1. Location of Dressing: (L) Eye Type: Pad c̄ Shield	(L) eye c̄ Shield		
	2. Location of Dressing: None Type:	Ø		
	3. Central Venous Device Dressing (every 72 hrs.): None	Ø		
	4. Additional Comments: None	LAc-HL		

SIGNATURE [signature] [signature] ______ ______

CO-SIGNATURE [signature] ______ ______ ______

0 0250

RA 0138

NEURO CHECK LEGEND

CHILD / ADOLESCENT		INFANTS												
EYE OPENING	SPONTANEOUS	4	SPONTANEOUS	3	TO SPEECH	2	TO PAIN	1	NONE					
	TO VOICE	3												
	TO PAIN	2												
	NONE	1												
VERBAL RESPONSE	ORIENTED	5	COOS / BABBLES	5										
	CONFUSED	4	IRRITABLE / CRIES	4										
	INAPPROPRIATE WORDS	3	CRIES TO PAIN	3										
	INCOMPREHENSIBLE WORDS	2	MOANS TO PAIN	2										
	NONE	1	NONE	1										
MOTOR RESPONSE	OBEYS COMMANDS	6	NORMAL MOVEMENT	6										
	LOCALIZES PAIN	5	WITHDRAWAL/TOUC	5										
	WITHDRAWS	4	WITHDRAWAL/PAIN	4										
	FLEXION	3	ABNORMAL FLEXION	3										
	EXTENSION	2	ABNORMAL EXTENSION	2										
	NONE	1	NONE	1										

		07	08	09	10	11	12	13	14
	COMMENTS		Assisted to (6)						
	TEMP.		98.7				99.9		
	PULSE		80				68		
	RESP.		16				16		
	B.P.		103/54				105/61		
NEURO ASSESSMENT	EYE OPENING		4				4		
	VERBAL RESPONSE		5				5		
	MOTOR RESPONSE		6				6		
	TOTAL		15				15		
	RIGHT PUPIL SIZE		5				6		
	RIGHT PUPIL REACTION		B				B		
	LEFT PUPIL SIZE		5				6		
	LEFT PUPIL REACTION		B				B		
	CSM CHECKS 1.) 2.)								
I. V. 'S	1. D5NS/2 20 mEq KCl		100	100	100	100	100	100	100
	2.								
	3.								
	SITE CHECKS 1.) Rt Ac 2.)								
INTAKE	ORAL FLUIDS		120				120		
	NG / GT FLUSH		N/A				N/A		
	NG / GT FEEDINGS		N/A				N/A		
OUTPUT	URINE		480				150		
	EMESIS		0				0		
	NG / GT		N/A				N/A		
	STOOL		0		15		0		
MISC.	CAPILLARY BLOOD SUGAR/INSULIN		N/A				N/A		
	O_2 SATS		0%				—		
	O_2 THERAPY		RA				R/A		
	APNEA MONITOR		N/A				N/A		
	FAMILY INVOLVEMENT		0				0		

PUPIL REACTIVITY
B - BRISK
S - SLUGGISH
N - NONREACTIVE

PUPIL SIZE
1 2 3 4
5 6 7 8

INTRAVENOUS START / RECORD

TIME	IV START KIT	RESTART	VEIN SITE	CANNULA SIZE	# ATTEMPTS	N.S. FLUSH	DRESSING CHANGE	ANTI-REFLUX LOCK	CANNULA D/C	COMMENTS	SIGNATURE

FAMILY INVOLVEMENT

MOM-MOTHER
DAD-FATHER
SIB-SIBLING
S/O-SIGNIFICANT OTHER
TCH-TEACHING DONE
ORT-ORIENTED

CALL-CALLED
VISIT-VISITED
HELD-HELD
FED-FED
BATH-BATHED

5	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
	(d)				Tylenol										
	99				98 (o)				98 (o)				98 (o)		
	64				68				94				69		
	16				19				18				18		
	108/65				104/55				105/55				116/68		
	4				4				4				4		
	5				5				5				5		
	6				4				6				6		
	15				15				15				15		
	6.15 Shilled				4B Shilled				4B Shilled				4B Shilled Nonreadevi		
					WNL				WNL						
100	100	NO	100	10V	1W	1W	10V	1W	1W	1W	100	10V	1W	1W	1W
				LAC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	120														
150	Ø		150			250			400	660			400/1050		425/147
	Ø														
	N/R														
	Ø														
	N/R														
	N/R														
	R/R														
	N/R				SCA										
	Ø					Ø									

LABEL

0 0252

RA 0140

NURSING PROGRESS NOTES

DATE: 5/22/04 (EACH S[illegible]S CHARTING WILL BEGIN WITH AN ASSESSMEN[illegible]MMARY)

(0800) Awake talkative Eye Shield (L) Eye in Place IV Continuous Site s̄ redness edema or tenderness Pos removed @ this time (1500 d/c'd) — [illegible]

(0930) Diet taken tol - [illegible] IV. Pain Improved 4/10 @ — Present. [illegible]

(1130) Nothing [illegible] Shield remain in Place - IV Continuous —

(1230) Diet completed 80% tol [illegible]

(1330) [illegible] OOB - Bedrest Maintained IV intact [illegible]

(1415) Mom + Dad VS - [illegible] rendered care [illegible]

(1500) Dr Carr VS + Examined — Pupil s̄ reaction Clot Noted Across pupil by Dr Carr. - Pressure measurement x3 - 13 - 11 - 12. [illegible] soft - OK / Dr Carr. [illegible]

(1700) Diet served taking diet [illegible]

(1840) [illegible] in Bed (L) Eye Shield in Place IV Infusing well @ [illegible] @ 100 cc/hr [illegible] 1500cc yellow urine [illegible] [illegible] [illegible]

(1945) Gave tylenol for c/o L eye pain. Shield intact. No [illegible]. [illegible] (2100) asleep [illegible]

(2300) asleep [illegible] (2400) [illegible] Back to sleep [illegible] (0200) asleep [illegible]

(0400) asleep [illegible] Eye [illegible] given [illegible] (0615) asleep [illegible]

0 0253

RA 0141

ROOM # 201

DAILY PEDIATRIC NURSING FLOW RECORD
24 HOUR – DATA SUMMARY

UMC
UNIVERSITY MEDICAL CENTER
LAS VEGAS, NV
89102

SIGNATURES	
0700 - 1900	
1900 - 0700	

ACCT: 0075603365 DOB 09/22/1992
PAYO, HAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

DATE FROM 0700 5/23/14 TO 0700 5/24

ISOLATION: ~~UNIVERSAL PRECAUTIONS~~ / AFB / CONTACT / RESPIRATORY CONTACT RSV / BODY FLUIDS / ENTERIC / STRICT

ALLERGIES: NKA

X-RAYS / PROCEDURES COMPLETED		TIME
1		
2		
3		
4		

SPECIMENS OBTAINED		TIME	INITIAL
1			
2			
3			
4			
5			
6			

MEALS / SNACKS

BREAKFAST	LUNCH	DINNER
DIET: Reg	DIET: Reg	DIET:
% TAKEN: 50%	% TAKEN: 60%	% TAKEN:
SNACK	SNACK	SNACK
TIME:	TIME:	TIME:
WHAT:	WHAT:	WHAT:

FORMULA Reg

WEIGHTS

YESTERDAY'S WEIGHT _____ KG.

0700 - 1900	1900 - 0700
TIME:	TIME:
WEIGHT: kg.	WEIGHT: kg.
ABDOMINAL GIRTH: cm.	ABDOMINAL GIRTH: cm.
HEAD CIRCUMFERENCE: cm.	HEAD CIRCUMFERENCE: cm.

SUMMARY OF FLUIDS IN		0700 - 1900	1900 - 0700	TOTALS
	IV	400		
	PO	120		
	NG			
	G-TUBE			
	TOTALS	520		24°

SUMMARY OF FLUIDS OUT		0700 - 1900	1900 - 0700	TOTALS
	URINE	100		
	NG			
	STOOL	—		
	EMESIS			
	TOTALS	100		24°

		0700 - 1900	1900 - 0700
HYGIENE	AM / PM CARE	E	
	ORAL CARE	E	
	SKIN CARE	E	
	MEATAL / FOLEY CARE	E	
	PERINEAL CARE	E	
ACTIVITY	ACTIVITY LEVEL:	Bedrest	
	SIDERAILS	UP x2	
	HEAD OF BED:	UP 30°	
	TYPE OF BED (circle) BED / CRIB / BASSINET / ISOLETTE		
SAFETY	SAFETY RISK: LOW / MED / HIGH Bedrest Eyeshield JG		

VISITS	HEALTHCARE TEAM VISITS:	TIME
	PHYSICIAN	Lazerson
	RESIDENTS	Fehr
	CONSULT:	optho
	CONSULT:	
	CONSULT:	
	PATIENT ADVOCATE	
	SOCIAL SERVICE	

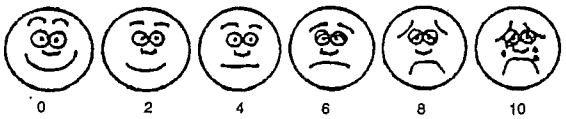
0 0254

RA 0142

Pain Management

Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	0000	0100	0200	0300	0400	0500	0600
Pt Perception of Pain 0-10	6	0	0	0	6	0	0	0	0															
FLACC	0				0																			
Location of pain	one				1																			
Characteristics of pain	SHP				SHP																			
Quality of pain	cont.				C																			
Interventions	one				1																			
Pt response to interventions 0-10	0				0																			
Intervention required by MD	0				0																			

Describe location of pain	1. Eye	2.	3.
Describe intervention	1. Pain med given	2.	3.



0 NO HURT · 2 HURTS LITTLE BIT · 4 HURTS LITTLE MORE · 6 HURTS EVEN MORE · 8 HURTS WHOLE LOT · 10 HURTS WORST

Pain Legend

D-Dull · A-Aching
ST-Stabbing · SHP-Sharp
B-Burning · SHT-Shooting
PR-Prickly

Quality legend

C-Continuous
I/A-Intermittent with activity
I/s-Intermittent without activity

FLACC Assessment

ASSESS	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant, quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arches, rigid or jerking
CRY	No cry (Awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOL ABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

MODIFIED BRADEN Q SCALE — SKIN RISK ASSESSMENT TOOL

Intensity/Duration of Pressure	1	2	3	4	Score
Mobility	Completely limited	Very limited	Slightly limited	No limitations	3
Activity	Bedfast	Chair fast	Walks occasionally	Ambulatory	1
Sensory perception	Completely limited	Very limited	Slightly limited	No limitations	3
Moisture	Constantly moist	Very moist	Occasionally moist	Rarely moist	4
Shear/Friction	Significant problem	Problem	Potential problem	No apparent problem	4
Nutrition	Very poor	Inadequate	Adequate	Excellent	3
Tissue perfusion/oxygenation	Extremely compromised	Compromised	Adequate	Excellent	3

Final score 21
Order # _____
Initials QN

Braden Scale

21-24 Static/Foam(lo risk)
18-21 Static/Foam (mod risk)
15-17 Low airloss/overlay (hi risk)
0-14 Specialized bed/air fluidized therapy when appropriate for age (hi risk)

CODES: NC - NO CHANGE FROM PREVIOUS ASSESSMENT; W/N - WITHIN NORMAL ASSESSMENT; N/A - NOT APPLICABLE

DATA BASE	DATE: [redacted] 23-04 TIME: 0800	TIME: [redacted]	TIME:	TIME:
SKIN AND MEMBRANES	1. Skin Turgor: Normal / Tented / Tight Sec.			
	2. Skin Color: Normal / Pale / Cyanotic / Flushed / Mottled			
	3. Skin: Warm / Cool / Dry / Diaphoretic / Clammy			
	4. Skin Lesions: None / Bruising / Petechiae / Rash Describe: Eyeshield on lt eye - redness Blood shot eye			
	5. Skin Integrity: Intact / Reddened / Breakdown / Decubitus Describe:			
	6. Mucous Membranes: Moist / Dry / Cracked / Lesions Describe:			
	7. Mucous Membrane Color: Normal / Pale / Cyanotic			
	8. Wound Location: o Steristrips / Sutures / Staples Clean / Dry / Intact / Reddened / Approximated			
	9. Wound Drainage: Color o Drains: Location			
	10. Peripheral Edema: None / Dependant / Pitting / Peri-orbital Location: Depth:			
	11. Additional Details: assess - observe			
NEUROLOGICAL	1. LOC: Alert / Lethargic / Responds to Pain / Irritable			
	2. Speech Pattern: Clear / Coos / Babble / Inappropriate for Age			
	3. Pupils: PERRLA / Nonreactive / Unequal			
	4. Sensation/Pain: Tingling / Numbness / Dull / Sharp / Burning / No Deficit Location:			
	5. Cry: High Pitched / Hearty / Weak NA			
	6. Fontannel: Soft / Flat / Bulging / Depressed NA			
	7. Additional Details: assess - observe			
CARDIO VASCULAR	1. Capillary Refill: Brisk / Prolonged Sec: <2			
	2. Peripheral Pulse: Strong / Weak / Where Palpated: Radial			
	3. Apical Pulse: Strong / Weak / Regular / Irregular / Murmur			
	4. Peripheral Clubbing: Yes / No			
	5. Additional Details assess - observe			
RESPIRATORY	1. Respiration: Unlabored / SOB / Grunting / Stridor / Nasal Flaring			
	2. Chest Excursion: Symmetrical / Asymmetrical / Retractions Type:			
	3. Auscultation: Clear / Crackles / Wheezing / Diminished / Location:			
	4. Breath Patterns: Eupnea / Tachypnea / Bradypnea / Apnea			
	5. Cough: Productive / Nonproductive / Absent / Loose / Barky			
	6. Sputum: Amount: Color: Consistency:			
	7. Tracheostomy: Type: Size:			
	8. Nasal Discharge: Yes / No Describe:			
	9. Additional Details: assess - observe			
GASTROINTESTINAL / ABDOMINAL	1. Abdomen: Soft / Firm / Rigid / Distended / Tender			
	2. Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent			
	3. N/G Tube: Patent / Clamped / Constant Suction / Intermittent Suction Describe Output:			
	4. N/G Feeding Tube: Enteral / Routine / NG / Gastrostomy: Tube / Button			
	5. Nutritional Feeding: Yes			
	6. Abdominal Drain:			
	7. Stools: Color: Consistency: Voluntary / Involuntary			
	8. Additional Details: assess - observe			
GENITOURINARY	1. Voiding: Continent / Incontinent / Indwelling Catheter / Diapers			
	2. Urine: Color yellow			
	3. Urinary Bladder: Not Palpable / Distended			
	4. Genitalia: Normal / Abnormal / Male / Female			
	5. Discharge: Site: Describe:			
	6. Additional Details: assess - observe			
PSYCHOSOCIAL INTERACTION	1. Affect: Calm / Irritable / Withdrawn / Angry / Smiling / Fearful			
	2. Family Visitation: At Bedside / Not Present / Called			
	3. Additional Details: assess - observe			
DRESSING CHANGES	1. Location of Dressing: Type:			
	2. Location of Dressing: Type:			
	3. Central Venous Device Dressing (every 72 hrs.): NA			
	4. Additional Comments:			

SIGNATURE [redacted]

CO-SIGNATURE [redacted]

0025

RA 0144

NEURO CHECK LEGEND

CHILD / ADOLESCENT		INFANTS	
EYE OPENING			
SPONTANEOUS	4	SPONTANEOUS	5
TO VOICE	3	TO SPEECH	4
TO PAIN	2	TO PAIN	3
NONE	1	NONE	2
VERBAL RESPONSE			1
ORIENTED	5	COOS / BABBLES	
CONFUSED	4	IRRITABLE / CRIES	6
INAPPROPRIATE WORDS	3	CRIES TO PAIN	5
INCOMPREHENSIBLE WORDS	2	MOANS TO PAIN	4
NONE	1	NONE	3
MOTOR RESPONSE			2
OBEYS COMMANDS	6	NORMAL MOVEMENT	1
LOCALIZES PAIN	5	WITHDRAWAL/TOUCH	
WITHDRAWS	4	WITHDRAWAL/PAIN	4
FLEXION	3	ABNORMAL FLEXION	3
EXTENSION	2	ABNORMAL EXTENSION	2
NONE	1	NONE	1

PUPIL REACTIVITY
B - BRISK
S - SLUGGISH
N - NONREACTIVE

PUPIL SIZE
1 2 3 4 5 6 7 8

		07	08	09	10	11	12	13	14	1
COMMENTS			pain				pain			
			@				@			
			Rt							
VITAL SIGNS	TEMP.	Rt	97.8				99			
	PULSE		79				84			
	RESP.		20				20			
	B.P.		101/53				101/59			
NEURO ASSESSMENT	EYE OPENING	Lt eye injury	4 (none)				4			
	VERBAL RESPONSE		5				5			
	MOTOR RESPONSE		6				6			
	TOTAL		15				15			
	RIGHT PUPIL SIZE		3				3			
	RIGHT PUPIL REACTION		B				B			
	LEFT PUPIL SIZE		3				3			
	LEFT PUPIL REACTION		B				B			
	CSM CHECKS 1.) 2.)									
I.V.'S	1. D5 1/2 NS + 20 KCL	100	100	100	100	100	100	100	100	
	2.									
	3.									
	SITE CHECKS 1.) 2.)	Rt hand	—	—	—	—	—	—	—	
INTAKE	ORAL FLUIDS		240		120			240		
	NG / GT FLUSH									
	NG / GT FEEDINGS									
OUTPUT	URINE		200			300			150	
	EMESIS									
	NG / GT									
	STOOL									
MISC.	CAPILLARY BLOOD SUGAR/INSULIN									
	O_2 SATS									
	O_2 THERAPY	RA								
	APNEA MONITOR									
	FAMILY INVOLVEMENT	Chart	0	0	0	0	0	0	0	

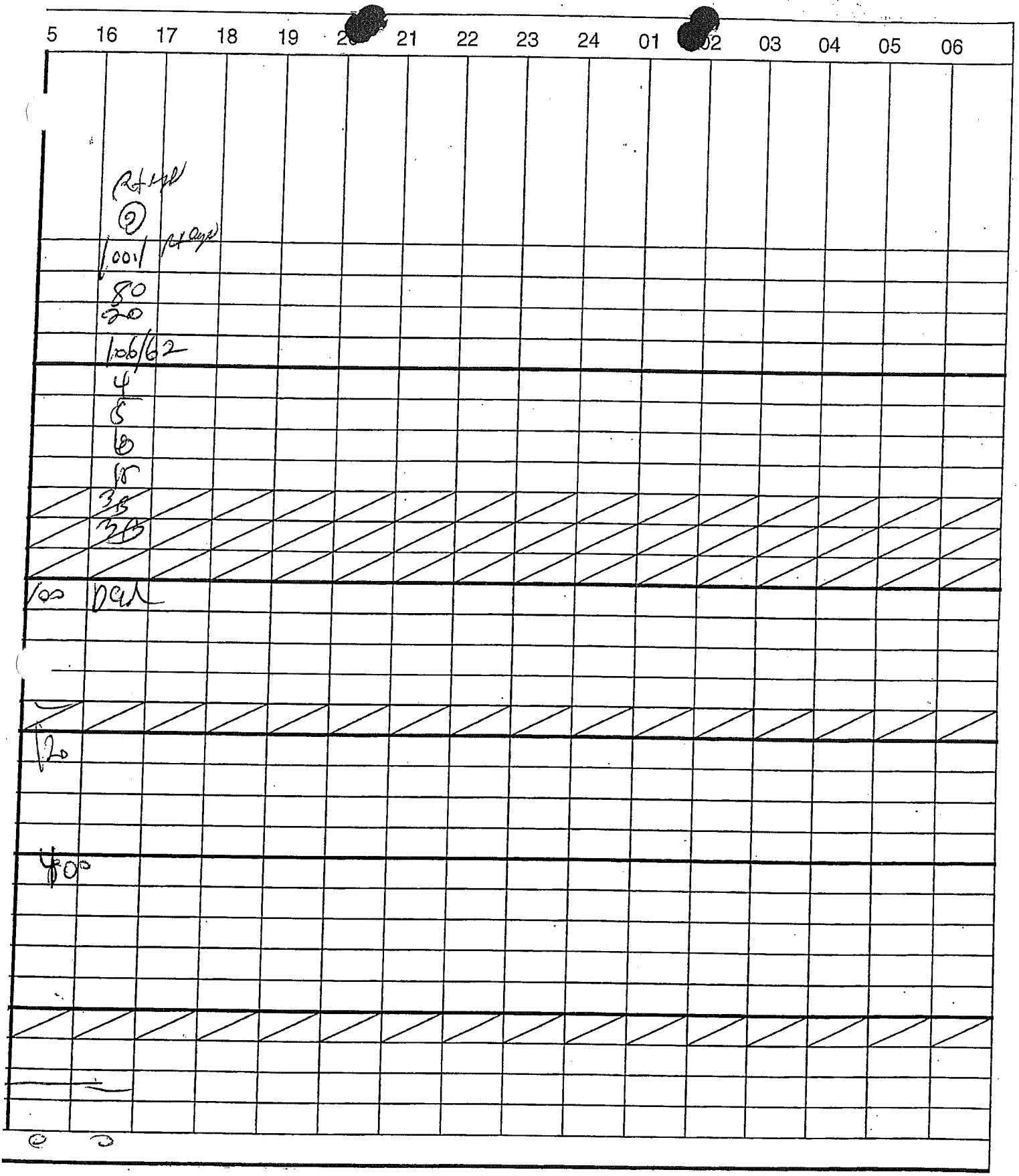
INTRAVENOUS START / RECORD

TIME	IV START KIT	RESTART	VEIN SITE	CANNULA SIZE	# ATTEMPTS	N.S. FLUSH	DRESSING CHANGE	ANTI-REFLUX LOCK	CANNULA D/C	COMMENTS	SIGNATURE

FAMILY INVOLVEMENT

MOM-MOTHER
DAD-FATHER
SIB-SIBLING
S/O-SIGNIFICANT OTHER
TCH-TEACHING DONE
ORT-ORIENTED

CALL-CALLED
VISIT-VISITED
HELD-HELD
FED-FED
BATH-BATHED



LABEL

0 0258

RA 0146

NURSING PROGRESS NOTES

DATE: 5/23/84 (EACH S[illegible]S CHARTING WILL BEGIN WITH AN ASSESSMEN[illegible]MMARY)

0720 Received report from night nurse. 0730 assumed care of patient - assessment done - see data base, BS clear, Asleep. 0800 IV of D5 1/2 NS + 20 meq KCl infusing well at 100 cc/hr. Ate breakfast well without emesis. 1000 asleep. Awake - Ancef given, voided. 1130 Medicated for pain [illegible] with gd. results. 1230 Ate lunch well without emesis, Dr. [illegible] in and checked eye pressure, shield replaced by Dr. [illegible]. 1400 Voided. Sleeping. 1500 Mother called about D/C home. IV D/C'd and removed. 1530 Mother given D/C instructions for follow up at [illegible]. Mother verbalized gd understanding of all D/C and aftercare instructions. Discharged with eyeshield and sunglasses on. No pain complaints, discharged ambulatory with mother. [illegible] RN

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

PATIENT INSTRUCTION FORM

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

FOR: _____

DATE	INSTRUCTIONAL INFORMATION	DEMONSTRATES UNDERSTANDING	NEEDS FURTHER INSTRUCTION	COMMENTS / REFERRALS MADE	SIGNATURE OF INSTRUCTOR
5/23/04	Eyedrop Instruction Follow up Appointment Discharge and Follow up Instruction	✓ ✓ ✓			

I HAVE BEEN INSTRUCTED ON THE ABOVE MATERIAL AND HAVE RECEIVED A COPY OF THIS FORM.

SIGNATURE: _____ DATE: 5/23/04

FORM 1822 REV: 1/03

UNIVERSITY MEDICAL CENTER
PEDIATRIC UNIT
VISITATION GUIDELINES

Patient Name MAKANI PAYO Room # 260 Bed #1

Communication Contact Person LORI PAYO

Relationship MOTHER Phone Number 813-5175

Please designate the best time for nursing or medical staff to contact the Communication Contact Person for an update _____

Do you understand that visitors may be asked to leave the patient room and return to the waiting room while procedures are being performed or during emergency crises?
Yes X No _____

Have you read the conditions and do you understand them?
Yes X No _____

Lori B. Payo
Signature of Communication Contact Person

Gail Guerrero RN
Signature of Witness

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-359 ADM 05/19/2004

0 0261

Pediatric Unit – 6/03

RA 0149

University Medical Center of Southern Nevada
Patient Personal Effects

ACCT 0075603365 DOB 09/22/1992
PAYOR AKANI E
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

Staff Initials

____ Patient arrived with NO Personal Effects

____ Clothing Destroyed ____ Prehospital _____ After arrival to hospital

X **Inventory not taken because patient will retain all personal items and expressly accepts all responsibility for such items.**

____ Items Specifically Retained by Patient: ☐ Glasses ☐ Dentures ☐ Hearing Aid(s)

Patient Signature: Lori Lazerson (MOM) Date: 5-19-04/1430

Staff Signature: Gail Guerrero RN Date/Time: 5-19-04/1430

Clothing Items

QTY IN	QTY OUT	Item & Description
1. ___	___	Belt
2. ___	___	Blouse
3. ___	___	Boots
4. ___	___	Bra
5. ___	___	Coat
6. ___	___	Dress
7. ___	___	Hat
8. ___	___	Jacket
9. ___	___	Pajamas
10. ___	___	Pants
___	___	Robe
___	___	Shirt
13. ___	___	Shoes
14. ___	___	Shorts
15. ___	___	Skirt
16. ___	___	Slippers
17. ___	___	Sneakers
18. ___	___	Socks
19. ___	___	Sweater
20. ___	___	Tie
21. ___	___	T-shirt
22. ___	___	Underwear

Personal Items

QTY IN	QTY OUT	Item & Description
23. ___	___	Back Pack
24. ___	___	Cane
25. ___	___	Cell Phone
26. ___	___	Checkbook
27. ___	___	Crutches
28. ___	___	Dentures
29. ___	___	Driver's License/ID
30. ___	___	Glasses
31. ___	___	Hearing Aid
32. ___	___	Keys
33. ___	___	Pager
34. ___	___	Passport
35. ___	___	Prosthesis
36. ___	___	Purse
37. ___	___	Radio
38. ___	___	Walker
39. ___	___	Wallet
40. ___	___	Weapon
41. ___	___	Wheelchair
42. ___	___	Other Items:

QTY IN	QTY OUT	Item & Description
43. ___	___	Bracelet (Yellow White)
		Comments
44. ___	___	Earrings (Yellow White)
		Comments
45. ___	___	Necklace (Yellow White)
		Comments
46. ___	___	Ring (Yellow White)
		Number & Color of stones (if applicable)
47. ___	___	Watch (Yellow White)
		Comments

Money Items

Paper IN	Paper OUT		Coins IN	Coins OUT	
___	___	$100	___	___	$1
___	___	$ 50	___	___	$0.50
___	___	$ 20	___	___	$0.25
___	___	$ 10	___	___	$0.10
___	___	$ 5	___	___	$0.05
___	___	$ 1	___	___	$0.01

___ ___ Casino Chips
___ ___ Credit Cards
___ ___ Food Stamps
___ ___ Money Order
___ ___ Travelers Checks
___ ___ Foreign Currency
___ ___ Other

INVENTORY PERFORMED BY: Date/Time:

Employee: Department:

Employee: Department:

VALUABLES #: CLOTHING #: WEAPONS #:

COMPLETE ON RELEASE:

Date/Time:

PERSONAL EFFECTS RELEASED TO: (Please specify and indicate Name of person taking responsibility for these items:

☐ Patient ☐ Family member ☐ Coroner ☐ Police
(Agency & Badge #)

☐ Other (Indicate relationship to Patient)

☐ ALL above Items Released ☐ INDIVIDUAL Item #'s Released: 0 0262

Patient Signature: Staff Signature:

UNIVERSITY MEDICAL CENTER
Southern Nevada

CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS AND THE RENDERING OF MEDICAL SERVICES

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-358 ADM 05/19/2004

I understand that my diagnosis is: Increase Left Ocular pressure, traumatic glaucoma

This requires the following medical service: Evacuation of Hyphema Left eye

☐My physician has explained the procedure and has answered all my questions.

☐I understand that there are risks with this procedure. These risks have been explained to my satisfaction. I also understand that there are rarer complications, including death, which may not have been specifically mentioned, that may also occur. I accept these risks.

☐I understand that there may be individuals that are not UMC employees in the operating room during the procedure.

☐My physician has informed me of the possible presence of these individuals.

☐The expected results of the procedure have been explained. No warrantee or guarantee has been made as to the result or cure.

☐Alternate methods of treating my condition has been explained to me, including no treatment, and the consequences and expected results of these alternatives have been described to my satisfaction.

☐I therefore authorize and direct D.W. Lazerson (Physician) and/or associates of the physician's choice to do the operation/procedure and/or any other therapeutic procedure that the surgeon's judgment may dictate to be advisable for the correction of this condition or for my (the patient's) well being.

☐I consent to the administering of anesthetics as are necessary.

☐ I authorize additional services as necessary, including Pathology and Radiology. The Pathologist may use discretion to dispose of any submitted tissue or member.

Patient's Signature (Date)

Witness 5-20-04 (Date)

Patient is (a minor) ☐ OR Patient is unable to sign ☐ Reason

Father/Guardian Date

Mother Lori B. Payo Date

Other Person: Date

Relationship Date

CONS013

(REV7/00

0263

RA 0151

UNIVERSITY MEDICAL CENTER

Southern Nevada

ACCT: 0075603365 DOB 09/22/1992
PAYO, MAKANI K
LAZERSON, JACK
MR# 001-191-350 ADM 05/19/2004

CONSENT FOR BLOOD/BLOOD COMPONENT TRANSFUSION(S)

1. I authorize the administration of such transfusion or transfusions of blood products _____ (Blood Product Name) to _____ Myself or Patient's Name as may be deemed advisable in the judgement of patient's attending physician, his associates or assistants. My physician has explained the risks, benefits, alternatives relating to blood transfusions.

2. It has been fully explained to me and I understand that blood transfusions are not always successful in producing a desirable result. It has also been explained to me and I understand that despite the exercise of due care, the transfusion of blood or blood products is always attended with a possibility of some ill effects, such as: the transmission of hepatitis; AIDS (acquired immunodeficiency syndrome); accidental immunization; or allergic reactions.

3. It has also been explained to me and I understand that emergencies do on occasion arise when it may be necessary to use existing stocks of blood which may not include the most compatible blood types.

4. I understand and agree that no guarantee or warranty (including the implied warranties of merchantability and fitness) applies to the blood or blood products which may be supplied.

5. I consent to the administration of blood and/or blood components. I have had ample opportunity to ask questions and have had any such questions answered to my satisfaction.

Patient or Person Authorized to Consent for Patient

Relationship to Patient

Witness

Date: 5-20-04

REV 9/96
CONS046

0 0264