ORLANDO HEALTH® | ARNOLD PALMER HOSPITAL For Children

LINE UP PATIENT I.D. LABEL HERE

❑ PEDIATRIC FACULTY PRACTICE
❑ PEDIATRIC NEPHROLOGY FACULTY PRACTICE
❑ PEDIATRIC ORTHOPEDIC FACULTY PRACTICE

HEALTH RECORD

Date_____ Completed by: ❑ Patient ❑ Parent/Guardian ❑ Other _____

Reason for visit: ❑ Check-up ❑ Problem (please list) _____

For Clinical Staff: Initial if physician review required

PLEASE COMPLETE THE FOLLOWING SECTIONS AS FULLY AS POSSIBLE:

Immunizations/Vaccines Are the child's vaccines current? ❑ Yes ❑ No

CONTAGIOUS DISEASES

Has the child (or anyone that lives in the same household as the child) had any of the following:

1. A history of MRSA or VRE infection? ❑ No ❑ Yes: Treated?_____ When?_____ _____
2. Recent exposure to chicken pox, shingles, scabies or lice? ❑ No ❑ Yes _____ _____
3. Any other infectious (contagious) disease? ❑ No ❑ Yes _____ _____

TUBERCULOSIS (TB) SCREENING

1. **Pediatric (children younger than 12)**

   Does the child, any member of the household, or anyone who frequently visits the household have TB? _____

   ❑ No ❑ Yes - **inform the Front Desk immediately**

   Does the child age 12 or greater (excluding Cystic Fibrosis patients), any member of the household, or anyone who frequently visits the household have a cough that has lasted longer than 2 weeks?

   ❑ No ❑ Yes - Complete the **Adult TB Assessmen**t on the child or adult in question _____

   Adult's Name _____ Relationship to Patient _____

2. **Adult (check the box if the answer is YES. If the answer is NO, leave blank)**

❑ Cough for longer than 2 weeks [3]	❑ History of TB or active TB (even if on meds) [5]
❑ Blood in the sputum [5]	❑ Jail in the past two years [2]
❑ Fevers or night sweats [2]	❑ HIV positive [2]
❑ Recent unexplained weight loss of > 10 lbs [2]	❑ Homeless or living in a shelter [1]
❑ Recent exposure to TB [2]	❑ Foreign born (Asia, E. Europe, Latin America, Africa) [1]

_____

USE OF TOBACCO PRODUCTS

Do you smoke or use tobacco of any kind? ❑ No Yes*

If patient is a minor and does not smoke, does anyone living in the house with the patient smoke? ❑ No Yes*

*Would you like to receive information on how to stop using tobacco products? ❑ No Yes

PSYCHOSOCIAL SCREENING:

Explain any Yes answers:

Do you have any behavioral and/or mental health concerns? ❑ No ❑ Yes _____ _____

Do you have any special religious and/or spiritual needs? ❑ No ❑ Yes _____ _____

Do you need additional emotional support during this visit? ❑ No ❑ Yes _____ _____

Is there any history of or current sexual, emotional, or physical abuse? ❑ No ❑ Yes _____ _____

Is there any history of or current domestic violence? ❑ No ❑ Yes _____ _____

For Office Use

Nursing/MOA Review:_____ Title_____ Date_____Time_____

Physician/Practitioner:_____ I.D.# _____ Date_____Time_____

STOP: OFFICE STAFF WILL COMPLETE BACK PAGE

TO BE COMPLETED BY OFFICE STAFF

Nursing/MOA Staff: Place your initials next to any "Yes" answers that require physician review

INSTRUCTIONS

IMMUNIZATIONS	If current per parent/guardian, verify on Vaccine Administration Record (VAR) (General Pediatrics Only)
CONTAGIOUS DISEASES	If "Yes" to any of these notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk.
IF A HISTORY OF MRSA/VRE	Initiate MRSA/VRE Protocol orders #5872-96739
TUBERCULOSIS (TB) SCREENING	**Pediatric [younger than 12]** – if "Yes" to this, notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk. **Adults [12 and older]** – add up points: Total points _____ If the patient has received 5 or more points, place a TB mask on the patient and place in a private room, using Airborne precautions. Contact the physician for an assessment.
USE OF TOBACCO PRODUCTS	If a patient answers yes to: *Would you like to receive information on how to stop using tobacco products?" offer the **TIPS TO KICK TOBACCO** booklet through Smartworks (4767-46341).
PSYCHOSOCIAL SCREENING	Any "Yes" answer must be addressed. Refer to Corporate P&P that details the requirements for healthcare workers. **SUSPECTED CHILD, ELDERLY, OR MENTALLY HANDICAPPED ABUSE OR NEGLECT: IDENTIFICATION AND REPORTING #1600** **SUSPECTED DOMESTIC VIOLENCE REPORTING (ADULT) #1625** **Abuse Hotline: 1-800-96-ABUSE**