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Paediatric Medical Step-down Facility/Hospice
Admission Assessment Document

REFERRING HOSPITAL / FACILITY: _____

PLEASE GIVE AS MUCH DETAIL AS POSSIBLE TO ENABLE US TO PROVIDE OPTIMAL CARE FOR THE PATIENT:

Patients Information:	
Surname:	Allergies:
Name:	Age:
ID Number:	D.O.B.
Gender: M/F	Place of Birth:
Cell Number:	Admission Weight:
Physical Address:	Admission Date:
Diagnosis:	

Next of Kin:

Name:	
Surname:	
ID Number:	
Relationship:	
Contact Telephone Number:	
Who to contact in case of Emergency:	
Relationship:	Tel Number:

Admission fee will be charged:

If a child has a SASSA card this has to be brought with on day of admission and handed over to us for us to claim whilst the child is in our care.

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Medical Aid Details if applicable:

Name of Medical Aid:
Membership no:
Name of main member:
Dependants:

Social Worker if applicable:

Name:
Cell Number:
Other Telephone Numbers:

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Patient's Medical History:

Current Diagnosis:
Patient History:
Chemo:
Radiation:
Surgery:
CD4 Count:
Viral Load:
Current Medication:
Current Feeds:

Prognosis of Patient:

Terminal	May improve with treatment	Chronic Life-Limiting

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Reason for Admission to Lambano Sanctuary:

Pain Control:
Nutritional Support:
Rehabilitation:
Respite Care:
Palliative Care:
Medication Adherence:
Other:

Name:			**D.O.B**
Symptomatic assessment	**Normal**	**Abnormal**	**Comments**
Level of consciousness			
Weight/centile			
Length/centile			
Head/centile			
Nutritional status			
Hydration			
T P R			
BP (if necessary)			
Colour			
JACOL: Jaundice, Anaemia, Cyanosis, Oedema, Lymph nodes			
Head			

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Neck			
Glands			
CVS: Murmurs Added sounds Other			
Abdomen: Spleen Liver Bowel sounds Genitalia Anus Other findings			
ENT: Ears Nose Throat			
Mouth			
Teeth			
Neuro			
Limbs			
MSK (including spine and hips)			

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Skin			
Clinical concerns re-HIV			

Has the patient and family received any counselling regarding the patient's condition?

Yes:	No:

HIV Information if applicable:

Does the child know his/her status	Yes	No
Is the rest of the family aware of patient's status?		
Is the patient attending a support group?		
Which support group?		

HIV Testing:

Pre-Test Counselling:	Yes	No	Date:	Where:
HIV Status:	Positive	Negative	Date:	

Antiretroviral Therapy:

Adherence Training Started	Date:	To whom:
Adherence Training Completed	Date:	To whom:
ARV's Commenced	Date:	

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Immunisation History:

Up to date: Yes No:

Number	Immunisation	Date Admin	Age
1.	BCG + Polio at birth		
2.	Polio, DTP, HiB, Hep. B (6 weeks)		
3.	Polio, DTP, HiB, Hep. B (10 weeks)		
4.	Polio, DTP, HiB, Hep. B (14 weeks)		
5.	Measles vaccine (9 months)		
6.	Polio, DTP, HiB, Hep. B (18 months)		
7.	Polio, DT (5 years)		
8.	Other vaccines (e.g. Varicella, Hep. A, MMR etc.)		

Road the Health Card Available: Yes / No

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Score Sheet TB Assessment for Children

A score of 7 or more indicates a high likelihood of TB

General	0	1	2	3	4	Total
Week of illness	<2	2-4		>4		
Nutrition % weight for age-appropriate	>80%	60-80%		<60%		
Family history of TB	None	Reported by Family		Proved sputum positive		
Tuberculin test				Positive		
Malnutrition				Not improving after 4 weeks		
Unexplained fever			No response to treatment			
Local						
				Lymph-nodes		
				Joint or bone swelling		
				Abdominal mass Ascites		
				CNS Signs abnormal		
X-rays				Broad mediastinum due to enlarge hilar glands	Angle deformity of spine	

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***NB**: By undersigning below you agree to accept and continue care for this patient should his/her condition complicate/deteriorate and require transfer to your acute facility.*

Completed by Dr:	Signature	Date

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