ALLERGIES:

DRUG	___ NO	___ YES*	EXPLAIN ______
FOOD	___ NO	___ YES*	EXPLAIN ______
ENVIRONMENTAL/OTHERS	___ NO	___ YES*	EXPLAIN ______
BLOOD PRODUCTS	___ NO	___ YES*	EXPLAIN ______
ANESTHESIA	___ NO	___ YES*	EXPLAIN ______
LATEX	___ NO	___ YES*	EXPLAIN ______
IF YES* ALLERGY BRACELET ON?		___ YES	___ NO

LATEX SENSITIVITY

LATEX ALLERGY CHECKLIST (If yes to any below, initiate Latex Allergy Protocol).	**YES**	**NO**
1. Allergy to bananas, avocados, chestnuts, kiwi, tropical fruit, tomatoes, potatoes, peaches, cherries, nectarines, poinsettias.		
2. History of myelodysplasia, spina bifida, or myeloma.		
3. History of edema, redness, or itching of skin after blowing up balloons, having dental procedures, or using a latex birth control device.		
4. History of contact dermatitis after using latex gloves.		
5. Multiple surgeries, including dental (inter-operative events consistent with anaphylaxis, episodes of urticaria, angioedema, respiratory distress, difficulty with ventilation, hypotension).		

PSYCHO/SOCIOCULTURAL

CUSTODY:
___ BOTH PARENTS
___ MOTHER
___ FATHER
___ PAPERS ON CHART

NEXT OF KIN:
NAME: ______
RELATIONSHIP: ______
ADDRESS: ______
PHONE NUMBER: ______

DAY CARE/SCHOOL:
NAME: ______
ADDRESS: ______
GRADE ______
APPROPRIATE FOR AGE ____ YES ___ NO* (IF NO, WHY) ______

CURRENT MEDICATIONS: ______
(include name < dose < frequency: how long taken).
FORM OF MEDICATION PREFERRED: ____ PILLS ____ CRUSHED ____ CHEWABLE ____ LIQUID ____ OTHER (______)

MEDS SENT TO PHARMACY FOR IDENTIFICATION ______ YES _____ NO MEDS SENT HOME W/FAMILY ____ YES ____ NO ____ N/A
HAVE BEEN ABLE TO FOLLOW PRESCRIBED MEDICATIONS? _____ YES ______ NO* WHY? ______

CASE MANAGEMENT

___ REFERRAL REQUESTED (IF YES, WHY? ______)

DO YOU HAVE ANY QUESTIONS REGARDING THE PATIENT RIGHTS OF YOUR CHILD? ____ YES ____ NO
IF YOU ARE NOT AVAILABLE, PLEASE INDICATE EMERGENCY CONTACT: ______

FUNCTIONAL SCREEN:

Instructions: For the following screens, please check box corresponding to the patients observed or reported condition. Include physician's name, date, and time notified that patient meets criteria for referral.

Physical Therapy (Requires MD order)	**Occupational Therapy (Requires MD order)**	**Nutrition** (Depending on nutritional risk, a dietitian referral is made using event code 501-8888) **High Risk:** (1 or more criteria)	**Moderate Risk:** (2 or more criteria)	**Low Risk:** (3 or more criteria)
❑ Neuro/Ortho surgery ❑ Orthopedics deformity ❑ Decreased ROM and muscle strength ❑ Burns/wounds ❑ Sensorimotor dysfunction ❑ Mobility or Assistive Device ❑ Special positioning consultation	❑ Greater than 4 months delay on Denver II ❑ Splints needed ❑ ADL dependent (not related to age)	❑ No identified needs ❑ Tube feedings/TPN ❑ Patient above 95% or Below 5th % on growth chart ❑ Renal disease, failure to thrive, cancer, HIV ❑ Severe food allergies ❑ New onset diabetes mellitus	❑ Modified/Restricted diet/specialized formula ❑ Chronic diarrhea ❑ Serum albumin < 3.2 dl ❑ Recent unintentional weight change > 5% in past month ❑ Chewing/swallowing problems resulting in poor po intake	❑ Receiving oral liquid nutritional supplement ♦ ❑ Persistent constipation ❑ Poor appetite/food refusal > 3 days ❑ Food allergies and/or intolerances ❑ Cultural/religious/ethnic food preferences

Yes/No		**At Risk for Falls:**
❑	❑	All children in crisis
❑	❑	All children sedated
❑	❑	sensorimotor impairment
❑	❑	uses mobility device

(if yes, start SOP injury prevention pediatric patients)

Outcome

❑ No referrals required
❑ Patient referred to: ______
❑ Parent/guardian request that referral not be made
❑ Physician ______ notified of need for referral Date/time: ______ / ______
❑ Patient currently receiving the following services at: ______

❑ PT ❑ SLP ❑ Home health ❑ OT ❑ Nutrition

SIGNATURE ______ DATE/TIME ____/____/______