TEMPLATE FOR PATIENT RECORDS – PAEDIATRICS - 2024

Remove sensitive information

In a consultation, begin with the concerns of the parent(s) and end with the most disliked part of the examination. Keep focused. Be detailed *when relevant*. There must be a *logical sequence* in your record. The **record is a legal document** that must describe your thinking and action with the precision and completeness necessary in a courtroom, including negative results – what is not there has not been asked about or examined. Be as precise as possible: In the history: Use dates or "x many days ago", not weekdays. In the status praesens: *Describe what you **observe**, **not** your interpretation of it!* Avoid spelling mistakes if possible.

History:

First, note how you got the information. Who's present? Direct interview? Telephone? Interpreter?

Reason for admission: Why is the patient admitted this time? (important in patients with several problems)

Social History: Patient's age and sex. Ethnic background, birthplace, language-understanding level of parent(s). Siblings and home environment (smoking, pets, carpeting). The child's level of care is important to note, including the number of caretakers, the work situation including occupation (important to give information at the right level) of the parents, childcare while parent(s) are at work (child day-care centre, school, after-school program – friends/hobbies?).

Family History: Diseases and hereditary disorders in the family, or other close relatives. Consanguinity. Deaths in the family if unknown cause.

Pregnancy and birth: Pregnancy, birth, reason for delivery if other than spontaneous contractions in mum at term. Neonatal period, including gestation, birthweight/- length and head circumference Neonatal period, as well as percentiles for all measurements. Nutritional state (length of breastfeeding). Health centre check-ups.

Immunization status (reasons if not vaccinated).

Growth and development: Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected. Habitual status if patient has psychomotor developmental disorder.

Medical history and hospital admissions: Previous illness, hospital admissions, health problems in childhood, exposure to risk of infection, allergies, and non-tolerable foods.

Present situation: Reason for consultation this time. Initiation and description of symptoms (gradual or sudden start). Specific symptoms (cough, laboured breathing, vomiting, diarrhoea, pain, etc). Obtain detailed and specific information and note the order with which the symptoms presented themselves. Describe the chronicity of each symptom independently.

Be open and listen to the parent(s)! It is very important to note the concerns of the parent(s).

Vegetative functions: (please, do not write "normal")
Urination – describe if possible (number of wet diapers etc), colour if appropriate
Defecation – describe frequency, consistency/colour (Bristol Stool scale)
Appetite – describe appetite, intake, and what the child eats
Sleep – describe – how many hours
Activity – describe the child's normal activity level, and any changes over time, if the child has declined

Medications: Any use of medications, including dosage and times if relevant.

Allergies: Adverse effects of medication including symptoms. Food allergies. Mandatory when assessing e.g. obstructive airways disease.

Status praesens; date and time:

Describe your observations, not your interpretation of it! Also, **negative findings are equally important** (example: no murmur, no enlargement of liver/spleen)

General description: X-month/year-old boy/girl. Describe general condition. Describe general health: well nourished, thin, etc. Hollow eyes, sunken fontanelle, reduced turgor?
Degree of contact. Movement. Cooperation during the examination.
Oedema. Rash/petechiae – describe and note size and location. Cyanosis. Jaundice.
Nuchal and back rigidity. Enlarged lymph nodes – where have your checked?
Respiratory distress? (tachypnoea, laboured breathing/ease of respiration, chest wall recession, use of accessory muscles of respiration, nasal flaring). Respiratory stable? Circulation – cold? warm? dry? extremities

Growth: Height (percentile) Weight (percentile) Head circumference (percentile, children ≤ 2 years old). If weight & height/length have not been done – you will have to do it! Excellent learning opportunity. Look up the percentiles for growth, pulse, RF and BP for age, ex: height 99 cm (50-75 centile). Weight 22 kg (2 kg above the 97th centile)

Vitals: *Under this section, we ask you to write down the reference range and whether the value is high, low, or normal for the age. NB, if the nurse has not taken measurements (e.g., temperature or blood pressure), you should measure them yourself*.

- Pulse (high, low, normal for the age) ex: Pulse/HR: 100 bpm (80-120) – normal for age
- Respiratory frequency (RF: XX/min (high, low, normal for the age),
- SaO2 in % - in room air or not?
- Blood pressure (high, low, normal for the age)
- Temperature – location (on the forehead, in the ear, in the axilla, or rectal tp)
- Capillary refill time in seconds (central/peripheral, high, low)

Specific examination of the body from top and downwards (in "anatomical order"):

Caput: Shape, symmetry. Fontanelles. Separation of the sutures.

ENT: Examination of the ears with an otoscope and examination of the throat should be made at the end of the consultation, but still noted in the "anatomical order" in the patient record.

Neck: Slightly enlarged glands are not uncommon. Describe enlarged glands (location, size, soft/hard, tender…)

Thorax: Inspection of the chest: chest symmetry, anatomical variation (pectus excavatum et carinatum), status after major surgery, retractions (subcostal, intercostal, supraclavicular, jugular), use of accessory muscles,

Cor: Inspection, Palpation (ventricular heave, displaced ictus, thrill), Auscultation; heart sounds – character: regular, normal heartbeats? Murmurs; systolic/diastolic, grade of murmurs (I-VI), location of murmurs. Percussion (rarely helpful in children).

Pulm: Auscultation (abnormal breath sounds: Stridor, crackles, wheeze, decreased breath sounds, expiratory grunting). Prolonged expiration? Assisted, forced respiration. Percussion (comparing sides)

Abdomen: Inspection, auscultation (bowel sounds), palpation (liver, spleen, masses), and percussion. Palpation should be done tenderly. Palpation for femoral pulses**.**

Genitalia and rectal examination: Normal feminine/masculine? Scrotum – often appropriate if abdominal pain. If the child wears a diaper – always open and check genitalia and look for diaper rash etc. Rectal examination is not part of the routine examination. When performed, the little finger should be used with young children.

Reflexes: Checking for primitive reflexes during the first months. These reflexes gradually disappear after three months of age, and should be absent after 6 months, except for the plantar grasping reflex, which is gone by the 9th month. Deep tendon reflexes can be examined from the 6th month.

Neurological screening: A brief neurological overview should be performed in all children (contact, muscle tone and patterns of movement), while a more detailed neurological examination is only done when indicated.

Supplementary investigations:

List investigations performed or planned with date/time relevance to the present complaint

- Imaging (x-ray, ultrasound, CT, MRI, scintigraphy ex. ++)
- Blood chemistry
- EEG, ECG, urinary test, faecal sampling, nasopharynx aspirate ++

Include all results! If results are not be available until after 1-2 days or later, you will have to log in later/come back later, make a plan with the doctor on call to get results when they are ready. Do not submit the journal until you have entered the test results. If not possible – comment your reasons for not doing it.

Summary and interpretation (including tentative diagnosis):

Patient record ends with a short summary of the patient history and examination findings – as much information in as few words as possible. This should **not include new information**, but rather the **essential points** of the patient history and examination. An interpretation of the symptoms and findings, leading to a conclusion with a *tentative diagnosis* should be clearly separated from the history and status.

Management plan:

Hospitalization or going home? Treatment initiated? No actions necessary? Information to the parents, GP, the Maternal-child-health care centre/"well-baby-clinic" (Helsestasjonen) for follow-up if patient is not admitted.

Please note that…

- Some of the learning this semester is for you to become confident examining children and skilled at history taking, which both are different than in adult patients. It could be that parents will ask you not to perform an examination such as looking in the mouth or the ears if a GP/emergency room and a doctor at Barnemottaket has already done it. That is ok, but generally, you should do most of it yourself.
- The nurses have not always done all the vital readings, such as blood pressure, weight/height if they do not see the necessity in just this case. You should at least get vitals (RF, HR, saturation, and temperature) and weight, length, and head circumference if the child is less than two years. If done, it can easily be seen on a **PEVS** (Paediatric Early Warning Score) – form, which you can bring into the room or copy before entering. If the values differ from the norm you must comment; for instance, caused by unrest, crying etc