

**Acute Assessment Document to be completed by CCN**

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| **Name: DOB: RXK:** |
| **SECTION 1 To be completed for all children** |
| **Heart rate: Temp: Respiration: SA02: (visits only)** |
| How is the child? (Please tick) **Same Better Worse** |
| Does the child have a temperature? **YES NO** |
| Has the child vomited? **YES NO**  If yes how many times |
| Rashes  **YES NO** |
| Does the child seem **Normal self Miserable Lethargic** |
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| **Section 2** : **To be completed for children with diarrhoea and vomiting** |
| Does the child have loose stools? **YES NO**  If yes how many times |
| Is the child eating and drinking? **YES NO**  How much/ Frequency? |
| **Section 3** **To be completed for children with respiratory problems** |
| Is the child wheezy? **Same Better Worse** |
| Does the child have a cough? **Same Better Worse** |
| Has the child got rapid breathing? **YES NO** |
| Has the child got intercostal recession **YES NO** |
| Is the child snuffly? **YES NO** |
| **Section 4(To be completed for all children)** |
| Are child’s parents/carers happy with child’s condition? **YES NO** |
| Advice given : |
| Need for further phone call? **YES NO** |
| Need for visit? **YES NO**  Date and time of visit arranged |
| Assessment Completed by:  Name: Signature: Job Title:  Date: \* Time:\* |

Paediatric Community Contact Sheet 

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| Surname: RXK:  Forename: DOB:    NHS No: Sex: | | |
| Date\Time |  | Signature |
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