

# PEDIATRIC EVALUATION

DEMOGRAPHICS		
PATIENT NAME	ADDRESS/CITY/STATE/ZIP	TELEPHONE
DATE OF BIRTH	AGE/SEX/RACE	NICKNAME
EMERGENCY CONTACT	ADDRESS/CITY/STATE/ZIP	TELEPHONE (DAY-NIGHT)
MOTHER	ADDRESS/CITY/STATE/ZIP	TELEPHONE (DAY-NIGHT)
FATHER	ADDRESS/CITY/STATE/ZIP	TELEPHONE (DAY-NIGHT)
PHYSICIAN	ADDRESS/CITY/STATE/ZIP	TELEPHONE
HOSPITAL	ADDRESS/CITY/STATE/ZIP	DATES OF STAY
PARENTS' EMPLOYER	ADDRESS/CITY/STATE/ZIP	TELEPHONE
REFERRAL SOURCE	ADDRESS/CITY/STATE/ZIP	TELEPHONE

BILLING			CLINICAL DATA		
SOCIAL SECURITY NO.	AGENCY NO.		PRIMARY DX	ICD-9	ONSET DATE
MEDICARE NO.	MEDICAID NO.		SECONDARY DX	ICD-9	ONSET DATE
OTHER INSURANCE	GROUP NAME	NUMBER	OTHER DX	ICD-9	ONSET DATE
PRIMARY PAYOR	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	RELEVANT SURGERY	ICD-9	DATE
	<input type="checkbox"/> OTHER INSURANCE		BIRTH RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
INSURED'S NAME	RELATION TO PT.	EMPLOYER	ACCIDENT RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	GRADE		DATE PLAN ESTABLISHED	ADM DATE	DATE CARE BEGAN
SCHOOL					

**SOCIOECONOMIC PROFILE**  
(CHECK ALL APPROPRIATE RESPONSES AND COMPLETE APPROPRIATE BLANKS)

INFORMANT	RELATIONSHIP
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**PRIMARY CAREGIVER**

NAME \_\_\_\_\_

RELATIONSHIP  PARENT  FRIEND/RELATIVE

HIRED ATTENDANT  OTHER (Specify) \_\_\_\_\_

WILLING  HESITANT  UNWILLING

NOT PAID  PAID

AVAILABLE AS NEEDED  LIMITED AVAILABILITY

HEALTH:  GOOD  FAIR  POOR

**RESIDENCE/LIVING ARRANGEMENT/SAFETY**

OWN HOME  ANOTHER'S HOME

SIBLINGS (NAME/AGE) \_\_\_\_\_

SAFE ENVIRONMENT  UNSAFE (Specify) \_\_\_\_\_

INTERCOM  SMOKE DETECTOR

IS ENVIRONMENT SUITABLE FOR TYPE, AMOUNT, LEVEL OF CARE ORDERED?  
 YES  NO

ADDITIONAL INFORMATION \_\_\_\_\_

**NUTRITION**

TYPE OF DIET:  REG.  OTHER (Specify) \_\_\_\_\_

FORMULA (TYPE/AMT. FREQ.) \_\_\_\_\_

INFUSION THERAPY:  NO  YES (Describe) \_\_\_\_\_

FEEDING TUBE:  NO  YES (Describe) \_\_\_\_\_

FOOD ALLERGY:  NO  YES (Specify) \_\_\_\_\_

NO. OF MEALS/DAY \_\_\_\_\_ FAVORITE MEAL \_\_\_\_\_

LIKES \_\_\_\_\_

DISLIKES \_\_\_\_\_

ADEQUATE FOOD INTAKE  YES  NO

ADEQUATE FLUID INTAKE  YES  NO

DESCRIBE NUTRITIONAL HABITS \_\_\_\_\_

**HOMEBOUND STATUS/AMBULATION**

ASSISTANCE REQUIRED:  MIN.  MOD.  MAX.

CONFINED TO BED:  NO  YES

REQUIRES HUMAN ASSISTANCE TO AMBULATE:  NO  YES

WHEELCHAIR/CANE/WALKER USE:  NO  YES

OXYGEN USE:  NO  YES OTHER DEVICE \_\_\_\_\_

**FINANCIAL INFORMATION**

SALARY INCOME  SOCIAL SECURITY/MEDICAID

INCOME ADEQUATE  INADEQUATE

**OTHER AGENCY ASSISTING PATIENT (CONTACT & PHONE)**

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