

PEDIATRIC PROGRESS NOTE

TIME IN: _____

TIME DISCHARGED: _____

DATE: _____ TELEPHONE: _____ AGE: _____ WT: _____ HT: _____ SEX: MALE FEMALE LMP: _____

B.P./H.C.: _____ T°: _____ P: _____ R: _____ ALLERGIES: _____ MEDICATIONS: _____

NURSING STAFF SIGNATURE

VISION		S:	
Right			
Left			
Both			
URINALYSIS			
Color			
Clarity		O:	
Leukocytes			
Nitrites			
Urobil			
Protein			
Ph			
Blood			
Specific Grav			
Ketones			
Bilirubin		A:	
Glucose			
AUDIOMETRY			
Yes – X No – O		P:	
	LEFT	RIGHT	
500			
1000			
2000			
4000			
LAB TEST			
		PATIENT EDUCATION TOPIC: _____ <input type="checkbox"/> Counseling <input type="checkbox"/> Pamphlets <input type="checkbox"/> Video	

NAME: _____

PROVIDER SIGNATURE: _____

DOB: _____

NURSING STAFF SIGNATURE: _____

MR#: _____

RTC IF SYMPTOMS WORSEN NEXT PHYSICAL IS DUE: _____

RTC: DAYS _____ WEEKS: _____ MONTHS: _____

INTERPRETER SIGNATURE: _____

SPAN VIET OTHER / HEARING IMPAIRED