PEDIATRICS

Pediatric sick visit

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

HISTORY

Parent, caregiver or patient present

Chief concern, onset and symptom course

Associated symptoms actually asked about and responses

Intake, output and activity as reported

Sick contacts, exposures and treatment already tried

Immunization status as reviewed

Medications and allergies

EVALUATION

Weight and vitals measured, with units

Hydration assessment findings

Focused examination findings

Testing obtained and results

ASSESSMENT AND MANAGEMENT

Working diagnosis and differential

Treatment provided or prescribed, with weight-based dose if applicable

Disposition and rationale

Return precautions explained and to whom

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding