

ID インプリント

**Interview Sheet Pediatric**

(小児準夜間)

受付時刻:

**For patients who come to the pediatric emergency department( weekends, holidays and nighttime).**

- Two pediatricians are on duty, for the whole hospital, during the night shifts and weekend/holiday shifts.
- St. Luke's is designated emergency hospital. Please be aware that in some cases there may be a delay in your consultation due to the need to conduct an emergency case.
- Emergency Medical Care is for emergency examination and treatment(administration).  
Your understanding and cooperation are deeply appreciated.

**Child's Name:** \_\_\_\_\_ **Male** • **Female** **Weight:** \_\_\_\_\_ **kg**

**Age:** \_\_\_\_\_ **Date of Birth: yy/mm/ dd** / /

**Kindergarten, School:** \_\_\_\_\_

- Major complaints, symptoms, or worries that brought you(your child)here today.  
When did the problem start? How long have you (he, she) been suffering from it?

- Are you currently undergoing treatment for any illnesses?  
( No • Yes: \_\_\_\_\_ )
- Have you (he, she) ever been allergic to medication, food or anything else?  
medication • food • asthma • atopic dermatitis • others  
(Detail about medication, food and the others \_\_\_\_\_ )
- Are you (he, she) presently taking medication? ( No • Yes )  
If yes, please show the note about the medication to a doctor.

~~~~~ For office use only ~~~~~

|                                              |            |             |           |                                                         |            |           |            |           |                 |
|----------------------------------------------|------------|-------------|-----------|---------------------------------------------------------|------------|-----------|------------|-----------|-----------------|
| <b>Pediatric Assessment Triangle</b>         |            |             |           | <input type="checkbox"/> N.P * 要観察時、該当項目に✓を入れ、( )に記入する。 |            |           |            |           |                 |
| <input type="checkbox"/> Appearance          | (          | T           | I         | C                                                       | L          | S         | )          |           |                 |
| <input type="checkbox"/> Work of Breathing   | (          |             |           |                                                         |            |           | )          |           |                 |
| <input type="checkbox"/> Circulation to Skin | (          |             |           |                                                         |            |           | )          |           |                 |
| <b>HR</b>                                    | <b>/m.</b> | <b>SpO2</b> | <b>%.</b> | <b>PR</b>                                               | <b>/m.</b> | <b>BT</b> | <b>°C.</b> | <b>BP</b> | <b>. CRT s.</b> |

判断理由: PAT 緊急度分類表 V/S異常 その他

1 • 2 • 3 • 4 • 5

トリアージ時刻 \_\_\_\_\_ 時 \_\_\_\_\_ 分 医療スタッフサイン \_\_\_\_\_

SLIH-2012.2.3-Ver.5.00