D-E-F Nursing Assessment Form

D: Distress

CONCERN?

Y N Pain?
"How is your pain right now?" "What is the worst pain you've had since this happened?"

Y N Fears and Worries?
"Sometimes kids are scared / upset when something like this happens. Has anything been scary or upsetting for you?" "What worries you most?"

Y N Grief or Loss?
Anyone else hurt or injured? Other recent losses?

E: Emotional Support

CONCERN?

Y N Do parents or child have trouble identifying coping needs / strategies?
[parent] "What helps your child cope with upsetting / scary things?"
[child] "What's the best thing so far that helps you feel better?"

Y N Barriers to parent availability to provide support?
Do parents: Find it hard to be with child for procedures? Find it hard to help calm/soothe child?

Y N Barriers to mobilizing existing support system?
"Who can you usually turn to for help / support?" "Any reasons they are not able to be helpful now?"

F: Family

CONCERN?

Y N Distress -- Parent, Sibling, Others?
"Any family members very upset since this happened?" "Who's having an especially difficult time?"

Y N Family Stressors?
"Are there other stresses for your family right now?" "Have you had trouble with getting sleep? with eating regularly?"

Y N Crucial to address other (non-medical) needs?
"Are there other worries (money, housing, family crises, etc) that make it especially hard to deal with this right now?"

Evaluation / Concerns: (Please document any "yes" findings above – continue on back if needed)

Assessor:_____Date:_____Time:_____

Plan: (If any concern checked above, please note plan here.)

- □ Add'l contact w/ family. GOAL:_____ Date:_____Time:_____ by:_____
- □ Feedback / instruction ABOUT: _____ Date:_____Time:_____ by:_____
- □ Provide patient education materials: _____ Date:_____Time:_____ by:_____
- □ Address pain management: Date:_____Time:_____ by:_____
- □ Attending physician notified (name):_____ Date:_____Time:_____ by:_____
- □ Child Life consult requested Date:_____Time:_____ by:_____
- □ Social Work consult requested Date:_____Time:_____ by:_____
- □ Psychiatry consult requested Date:_____Time:_____ by:_____
- □ Psychology consult requested Date:_____Time:_____ by:_____
- □ Chaplaincy requested Date:_____Time:_____ by:_____
- □ Other: _____ Date:_____Time:_____ by:_____
- □ Other: _____ Date:_____Time:_____ by:_____