

As part of the Essential Clinical Dataset (ECD) work, the admission form for Pediatrics has been updated to include the information that should be documented by nursing during the admission history process and removed data that is documented elsewhere in the electronic health record (EHR) and/or is part of another workflow.

Changes within the Admission History Pediatric Form

➤ General Info

- Removed the following documentation fields:
 - **Preferred Name** (recorded by Registration and flows to the Banner Bar and patient ID bracelet)
 - **Admitted From** (recorded by Registration)
 - **Patient Requests Family/Significant Other to be Notified of Admission**
- Changed the following documentation titles:
 - **Preferred Mode of Communication** changed to **Patient/Caregivers Preferred mode of Communication.**
 - **Primary Language** changed to **Patient/Caregivers Primary Language.**
- Added the following documentation fields:
 - **Primary Caregiver and Child’s Legal Parent(s) or Guardian**
 - Added additional documentation for **court orders, type of court order and court ordered limitations/restrictions.**
 - **Transfusion History** has been moved to this section.

ID Risk Screen
General Info
Interpreter Services
CSSRS Screen
Nutrition
Spiritual/Visitors
Living and Resources
Social History
Alcohol Screening
Procedure History
Education Needs
Influenza Screening
COVID-19 Precaution
Breast/Formula Feeding

➤ Nutrition

- **Formula Type** has been alphabetized and contains only formulas. Types of nipples have been moved to **Nipple Type**.

➤ Spiritual/Visitors

- This section is a combination of the former **Family/Social** and **Psychosocial/Spiritual** sections.

➤ Living and Resources

- Removed the following documentation field:
 - **Lines/Tubes Present on Admission** (this is documented in the applicable dynamic group in iView).