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 <u>not</u> able to be helpful now?"

F: Family

CONCERN?

Y N **Distress -- Parent, Sibling, Others?**
"Any family members <u>very</u> 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.)

WHEN WAS THIS ACTION COMPLETED?

- □ 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:_____