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:____