Vancouver Coastal Health
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

PEDIATRIC HOSPITAL D/C SUMMARY

Name:		**Assessment Date:**	**PARIS ID:**
DOB:	**Age:**	**Assessment End Date:**	
Gender:		**Physician:**	
PHN:		**School Name:**	
Home Address:		**Phone:**	

Parent(s)/Guardian(s)

Name	Home Phone	Work Phone

Other People Involved with Assessment

Who	Association	Comments

Background

Relevant Family Information

Relevant Medical History

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments

Allergies - Current

A / S	Date Entered	Allergen	Reaction	Comment

Current Medical

Central Nervous System

Respiratory

Cardiovascular System

PEDIATRIC HOSPITAL D/C SUMMARY

Name:	PARIS ID:

Gastro-Intestinal

Genito-Urinary

Infectious Diseases

Hematology and Lab Results

Skin

Medication

Medication Name	Dose	Route	Frequency	Start Date	End Date

Pediatric Summary/Recommendations

☐ Phoned

☐ Faxed to Non-VCH Staff

Seen by In Hospital Resource

☐ Lactation Consultant for Mother

☐ Hospital Social Worker

☐ Ministry of Children and Families

☐ Other

Other (Specify)

PEDIATRIC HOSPITAL D/C SUMMARY

Name:	PARIS ID:

Referred to Community Resources

- ☐ Infant Development Program (IDP)
- ☐ Centre for Abilities

  At Home Program - Assessment
  - ☐ Assessment
  - ☐ Funding
  - ☐ Nursing Support Services
- ☐ Other

  Other (Specify)

Other Comments

Recommendations

Copies To Be Sent To

Casenote (may have been added after assessment end dated)

Signature: _____

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

---------- End of Report ----------