



# Frequently used clinical forms: Nursing

**This document includes a list of the frequently used clinical forms for nurses and identifies if they are transitioning into the ieMR or staying on paper. For a full list, please visit the ieMR resources web page or the QHEPs Clinical forms catalogue.**

Please note, the following form types will stay on paper:

- all clinical pathways and care plans
- all criteria led discharge forms, parent/carer discharge checklists and transfer checklists (inter and intra hospital)
- all consent forms
- all referrals and booking request forms
- all non-invasive ventilation orders (note, observations for patients on NIV will be documented in ieMR).

Form name	Digital	Paper
24 Hour Fluid Balance Chart	Yes	No
Acticoat Maintenance	No	Yes
Acticoat Maintenance on Clinitron™ Bed	No	Yes
Advanced Respiratory Observation Form	Yes	No
Basic Spinal Observation Chart	No	Yes
Blood Product Transfusion Prescription and Administration Record	Yes	No
Bowel Chart	Yes	No
Bronchiolitis High Flow Children's Early Warning Tool (CEWT) - ALL AGES	Yes	No
Case Conference Record	No	Yes
Catheter Observation Chart	Yes	No
Children's Early Warning Tool (CEWT) Tertiary and Secondary - ALL AGES	Yes	No
Children's Early Warning Tool (CEWT) CARDIAC (Trial) - ALL AGES	No	Yes
Children's Early Warning Tool for Hospital In The Home (CEWT HITH) - ALL AGES	Yes	No
Children's Hospital MRI Safety Questionnaire (Child and Parent)	No	Yes
CHQ At Home Treatment Plan & Referral	No	Yes
Clinical Rounding Log	Yes	No
CVAD Daily Assessment	Yes	No
Daily Patient Care Record Risk Assessment Child	Yes	No
Emergency Department Children's Early Warning Tool (CEWT) - ALL AGES	Yes	No
ENT Pre-Admission Checklist	No	Yes
Enteral Feeding Order	Yes	No
Entonox Procedural Sedation	No	Yes
External Ventricular Drain Observation Sheet	No	Yes
Feeding Chart	Yes	No
Fluid Balance Summary	Yes	No
Heparin Intravenous Infusion Order & Administration	Yes	No
Initial Clinical Assessment and Risk Screening Tool (Tertiary)	Yes	No

**Contact the ieMR team for more information.**

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Form name	Digital	Paper
Insulin Intravenous Infusion Order and Blood Glucose Record	Yes	No
Intracranial Pressure Records	Yes	No
Intravascular & Subcutaneous Fluid Order Form	Yes	No
N-Acetylcysteine Fluid Order	Yes	No
Neurological Assessment Chart (Infant Child Adult)	Yes	No
Neurovascular Observation Chart Lower Limb	Yes	No
Neurovascular Observation Chart Upper Limb	Yes	No
Niki Pump Infusion Record	Yes	No
Observations Radiant Warmer	Yes	No
Opioid Infusion Assessment Chart	Yes	No
Oxygen Medication Chart	Yes	No
Paediatric Falls Risk Assessment and Management	Yes	No
Paediatric Fluid Balance Chart	Yes	No
Paediatric Insulin Subcutaneous Order and Blood Glucose Record	Yes	No
Paediatric Multi Input Fluid Balance Chart	Yes	No
Pain Management Prescription	Yes	No
Parent to Child Interaction Observation Record	No	Yes
Parent/Carer Skills Assessment for Central Venous Access Devices	No	Yes
Parent/Carer Skills Assessment for Home Parenteral Nutrition	No	Yes
Phototherapy Observation Chart	Yes	No
Point of Care Testing	Yes	No
Procedural Sedation Record	No	Yes
Respiratory Observation Chart	Yes	No
Resuscitation Data Sheet	No	Yes
Seizure Chart	No	Yes
Seizure Emergency (and Midazolam) Instruction	No	Yes
Sleep Chart	No	Yes
Specific Observation Chart	Yes	No
Stoma Care Progress Record	Yes	No
Sub-Acute Care (SNAP) Form	No	Yes
Tobramycin/Gentamicin Therapeutic Drug Monitoring	Yes	No
Tonsillectomy (+/-) Adenoidectomy Observation Sheet	No	Yes
Tracheostomy Care Bedside Equipment Checklist	No	Yes
Trial of Fluids	No	Yes
Vancomycin Therapeutic Drug Monitoring	Yes	No
Variable Frequency Medication Chart	Yes	No
Video EEG Observation & Patient Rounding Log	No	Yes
Ward ReADI	No	Yes
Warfarin Therapy Chart	No	Yes
Weight Chart	Yes	No
Wheeze Action Plan	No	Yes
Withdrawal Assessment Chart	No	Yes

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