

Care Plan – Poke and Procedure

MRN:

NAME:

BIRTHDATE:

CSN:

Today's date: ____/____/____ (mm/dd/yyyy)

Comfort measures for (child's name): _____How would you describe **your/your child's** experience (s) with previous needlesticks/procedures? no problems cries worries very fearful no previous experience

Comments: _____

**Information:**Does the patient have a central line or port? yes no Can we draw labs from it? yes no

Would the patient like (check all that apply):

 step-by-step instructions to be awakened for poke curtain pulled/privacy**People:** Who would the patient like to be involved in the needlestick/procedure? parent staff Child Life staff member (when available)**Position:** Does the patient prefer to: lie flat sit up be held**Watching:** Does the patient prefer to: watch not watch**Distraction:** Would the patient like (check all that apply): count out loud "1, 2, 3," then poke bubbles book TV other distraction ideas (specify): _____**Comfort Measures:** Does the patient use any of these comfort measures? (check all that apply)*For infants:*

- swaddle
 caress
 pacifier
 sucrose

Children of all ages:

- imagery (e.g. my favorite place)
 deep breathing
 my own comfort item (stuffed animal, book, music)

Would you like to use other measures? Buzzy® (vibrating device) other (specify): _____**Additional comfort measures and notes:** _____

Printed name of person filling out this form _____

Relationship to patient _____

Child Life Specialist (Phone number _____) when available can assist with choosing individualized comfort measures.*If the Poke Plan does not result in a successful needlestick with minimal pokes, staff has the responsibility to seek other options to complete the procedure.*Staff Signature _____ Date: _____ Time: _____ A.M. / P.M.
(mm/dd/yyyy)To find more information about the Poke Program go to <http://www.med.umich.edu/pdf/pediatric/pokeprogramflyer.pdf> or contact the C.S. Mott Children's Hospital Family Center at 734-936-8253 for more information.