

SIMPLE FEBRILE SEIZURE CHART REVIEW TEMPLATE (03-26-25)

HOSP. CODE/VISIT DATE:	PT AGE/SEX:	MR #:	MD REVIEWER:
INCLUSIONS: All Patients with a disc EXCLUSIONS: Age >5 years or < 6 mo			
1) TRIAGE/HISTORY/PHYSICAL EXAM:		3) LABS/IMAGING/SPECIAL TESTS	
ND = Not documented		<u>CI = Clinically Indicated</u>	
1a) Respiratory rate recorded.		CI <u>3a</u>) Lumbar puncture done (credit if performed for concern for meningitis or intracranial infection as documented in decision making)	
<u>1b</u>) Heart rate recorded.			
<u>1c</u>) Temperature recorded.		CI <u>3b</u>) CT head performed	
1d) Weight Kg. recorded.		(credit if performed if concern for intracranial infection or trauma as documented in decision making)	
<u>1e</u>) Fever (T \geq 38°) on PE, or history of fever or illness at home.		3c) Chemistry panel ordered (credit if signs of dehydration documented)	
1f) History of generalized seizure involving all four extremities lasting ≤ 15 minutes, non-focal neurologic exam, and no recurrence in 24 hours.			
			blood count ordered gns of dehydration documented)
1g) Documented not seriously ill.		4) DISPOSITION	
(credit for any 2 but at least 1 fea	ture from each category)		
→ Alert _	Smiling		baseline mental status documented prior to (NA if admitted)
Playful	Consolable ANDNot ill-appearing	4b) Discharge instructions provided, with follow-up recommendations, return precautions, information on diagnosis (NA is admitted)	
Normal sk Normal pe	in color		

2) TREATMENT/MANAGEMENT:

- 2a) Antipyretics administered for fever
- 2b) Benzodiazepine administered for active seizure
- $\underline{2c}$) Medications administered with correct weight-based dosing