

PEDIATRIC Evaluation for Severe Sepsis Screening Tool

1. Is the patient's history suggestive of an *infection*?

- | | | |
|---------------------------|--------------------------------|------------------------------|
| Pneumonia | Skin/soft tissue infection | Endocarditis |
| Empyema | Bone/joint infection | Implantable device infection |
| Acute abdominal infection | Bloodstream catheter infection | Meningitis |
| Urinary tract infection | Wound infection | Other _____ |

YES ____ NO ____

If **any one** of the above under #1 is present, select YES.

2. Are any **two** of the following signs & symptoms of *infection* both present and not considered to be chronic? Note: Laboratory values may not be available. Solicit order from MD if needed.

- | | |
|---------------------------------|---|
| Hyperthermia > 101°F | Acutely altered mental status |
| Hypothermia < 96.8°F | Leukocytosis (see chart on back) |
| Tachycardia (see chart on back) | Leukopenia (see chart on back) |
| Tachypnea (see chart on back) | Hyperglycemia (plasma glucose > 120 mg/dl) in the absence of diabetes |
| | Chills with rigors |

YES ____ NO ____

If **two or more** of the above under #2 is present, select YES.

3. Are any of the following organ dysfunction criteria present and not considered to be chronic or a result of therapy?

- SBP (see chart on back)
- Bilateral pulmonary infiltrates with a new (or increased) oxygen requirement to maintain SpO₂ > 90%
- Creatinine > 2.0 mg/dl or Urine output < 0.5 ml/kg/hour for > 2 hours
- Bilirubin > 2 mg/dl
- Platelet count < 100,000
- Coagulopathy (INR > 1.5 or PTT > 60 sec)
- Lactate > 2 mmol/L
- Other _____

YES ____ NO ____

If **any one** of the above under #3 is present, select YES.

If **YES** to all 3 items above, the patient meets the criteria for possible **SEVERE SEPSIS**.

*****If a positive screen call an RRT and/or notify the MD immediately. *****

Physician notified of positive screen?

Yes Time _____ No Reason: _____

New Orders Received: _____

Signature _____ Unit or Room: _____ Date: _____ Time: _____

NOT A PERMANENT PART OF THE MEDICAL RECORD

(Forward completed form to B. Miller in FRU via intercampus Mail)



Age-specific vital signs and laboratory variables

(lower values for heart rate and leukocyte count are for the 5th and upper values for heart rate, respiration rate, or leukocyte for the 95th percentile)

Age Group	Heart Rate (Beats per min)		Respiratory Rate (Breaths per min)	Leukocyte Count (Leukocytes X 10,000)
	Tachycardia	Bradycardia		
0 days – 1 week	>180	<100	>50	>34
1 week – 1 month	>180	<100	>40	>19.5 or <5
1 month – 1 year	>180	<90	>34	>17.5 or <5
2 -5 years	>140	NA	>22	>15.5 or <6
6 – 12 years	>130	NA	>18	>13.5 or <4.5
13 to < 18	>110	NA	>14	>11 or > 4.5

Age-appropriate limits for hypotension

Age Group	Systolic Blood Pressure, mm Hg
Newborn – 30 days	≤ 60
1 month – 1 year	≤ 70
> 1 year – 10 years	≤ 70 + 2x (age in years)
> 10 years	< 90