

**CHART REVIEW TEMPLATE  
FEBRILE SEIZURE**

Date: \_\_\_\_\_  
Patient No. \_\_\_\_\_

INCLUSIONS: All Patients with a discharge diagnosis of "Febrile Seizure"

EXCLUSIONS: Age <6 months or >5 years; history for seizure disorder or antecedent neurological problems.

1) TRIAGE/HISTORY/PHYSICAL EXAM: (36 points)

<u>Point Value</u>	<u>ND = Not documented</u>	
___ <input type="checkbox"/> 4 Yes <input type="checkbox"/> 0 No		1a) Respiratory rate recorded.
___ <input type="checkbox"/> 4 Yes <input type="checkbox"/> 0 No		1b) Heart rate recorded.
___ <input type="checkbox"/> 4 Yes <input type="checkbox"/> 0 No		1c) Temperature recorded.
___ <input type="checkbox"/> 4 Yes <input type="checkbox"/> 0 No		1d) Weight recorded.
___ <input type="checkbox"/> 10 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		1e) Fever ( $T \geq 38^\circ$ ) on PE, or history of fever at or illness at home. (no credit for ND)
___ <input type="checkbox"/> 5 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		1f) History of generalized seizure involving all four extremities lasting $\leq 15$ minutes, nonfocal neurologic exam, and no recurrence in 24 hours. (no credit for ND) [Go to 1h) if Y, go to 1g) if N]
___ <input type="checkbox"/> 10 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		1g) History of focal seizure, or seizure lasting > 15 minutes, or more than 1 seizure in 24 hours. (no credit for ND) [Go to 3a]
___ <input type="checkbox"/> 5 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		1h) Documented not seriously ill. (credit for any 2 but at least 1 feature from each category) [Go to 2a if Y, 1i) if No]
<b>Must choose one</b> } <input type="checkbox"/> Alert <input type="checkbox"/> Smiling <input type="checkbox"/> Interactive <input type="checkbox"/> Playful <input type="checkbox"/> Consolable		
	<b>AND</b>	
<b>Must choose one</b> } <input type="checkbox"/> Non toxic <input type="checkbox"/> Not ill-appearing <input type="checkbox"/> No nuchal rigidity <input type="checkbox"/> Normal fontanelle <input type="checkbox"/> Normal skin color <input type="checkbox"/> Normal perfusion <input type="checkbox"/> Normal capillary refill.		
___ <input type="checkbox"/> 5 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		1i) Documented seriously ill. (Credit for 1 or more of the following signs: [Go to 3a) if Y, go 2a) if No or ND]
<b>Must choose one</b> } <input type="checkbox"/> Inconsolable <input type="checkbox"/> Listless <input type="checkbox"/> Poorly Interactive <input type="checkbox"/> Lethargic <input type="checkbox"/> Toxic appearance <input type="checkbox"/> Ill-appearing <input type="checkbox"/> Nuchal rigidity <input type="checkbox"/> Bulging fontanelle <input type="checkbox"/> Unresponsive		

LABS/IMAGING/SPECIAL TESTS (64 points)

Point Value      ND = Not documented – credit if not documented

___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 5 No <input type="checkbox"/> 5 ND <input type="checkbox"/> NA		2a) Lumbar puncture done in child 18 months through 5 years of age. (full points for No, ND, NA)
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND		2b) EEG scheduled or done.
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND		2c) CT of head scheduled or done.
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND		2d) MRI of head scheduled or
___ <input type="checkbox"/> 5 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		2e) Signs of dehydration (to include 1 or more of the following dry mucous membranes, sunken eyes, poor skin turgor, tenting, or lethargy/postictal >30 minutes) documented. (No credit for ND) [If Y Go to 3 e-h), if N Go to 2f)]
___ <input type="checkbox"/> 5 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 0 ND		2f) No signs of dehydration (to include 1 or more of the following: moist mucous membranes, crying with tears, alert and active) (No credit for ND) [Go to 2 g-]
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 6 No <input type="checkbox"/> 6 NA		2g) Electrolytes ordered.
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 6 No <input type="checkbox"/> 6 NA		2h) Serum calcium ordered.
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 6 No <input type="checkbox"/> 6 NA		2i) Serum phosphorous ordered.
___ <input type="checkbox"/> 0 Yes <input type="checkbox"/> 6 No <input type="checkbox"/> 6 NA		2j) Serum magnesium ordered
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___ <input type="checkbox"/> 10 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND <input type="checkbox"/> 10 NA		3a) Lumbar puncture performed
___ <input type="checkbox"/> 10 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND		3b) EEG scheduled or done.
___ <input type="checkbox"/> 10 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND		3c) CT of head scheduled or done.
___ <input type="checkbox"/> 10 Yes <input type="checkbox"/> 10 No <input type="checkbox"/> 10 ND		3d) MRI of head scheduled or done.
___ <input type="checkbox"/> 6 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 6 NA		3e) Electrolytes ordered.
___ <input type="checkbox"/> 6 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 6 NA		3f) Serum calcium ordered.
___ <input type="checkbox"/> 6 Yes <input type="checkbox"/> 6 No <input type="checkbox"/> 6 NA		3g) Serum phosphorous ordered.
___ <input type="checkbox"/> 6 Yes <input type="checkbox"/> 6 No <input type="checkbox"/> 6 NA		3h) Serum magnesium ordered.

**TOTAL:** \_\_\_\_\_

