

# Pediatric Appendectomy Post-Operative Assessment Form

Patient Name

Medical Record Number

Date of Surgery

Age

Gender



## Assessment

Vital Signs

Pain Assessment

Wound Assessment

Drain Output (if applicable)

Oral Intake

## Gastrointestinal Status

Bowel Sounds

Passing Flatus/Stool

**Urinary Status**

Voiding

**Mobility/Activity**

Ambulation

**Medications**

**Complications/Concerns**

**Plan**

Date of Assessment

Assessed By