

Suzhou University Affiliated Children's Hospital (Park General Campus)

Doctor-Patient Communication Record

Record 1

Basic Information

Name:

Department: Pediatric Intensive Care Unit (Park)

Ward: PICU

Bed No.: ICU30

Hospital Admission No.:

Patient: Male, 3 months and 4 days old

Time: 14:37, May 28, 2022

Location: PICU Interview Room

Communication Contents (Including Condition, Diagnosis, Treatment, Prognosis, Risks, Complications, Medical Expenses, etc.)

1. Current diagnosis of the child: Fever of unknown origin; suspected Langerhans cell histiocytosis.
2. After admission, complete examinations including biochemistry, coagulation function, blood gas analysis, cranial, thoracic and abdominal CT to evaluate the disease status. Relevant clinical departments will be consulted to determine whether repeated or multiple tissue biopsies are required to confirm the diagnosis.
3. Condition assessment: Based on the existing medical history, Langerhans cell histiocytosis is highly probable, combined with multiple organ damage, severe malnutrition and immunodeficiency. Disease progression may cause multiple organ failure and death. The child already has bone destruction, and spontaneous fracture may happen during hospitalization. The primary disease is severe and progressive. Due to severe malnutrition and poor immune

function complicated with otitis media, infection can spread rapidly, resulting in other organ infections such as central nervous system infection and visceral abscesses. In critical cases, septic shock may occur and endanger life.

4. Suzhou University Affiliated Children ' s Hospital integrates medical treatment, teaching and scientific research. The child ' s clinical data (excluding private information such as name, family address, registered permanent residence address, phone number and hospital admission number) can be used for clinical research.

All the above contents have been communicated to the guardian, who fully understands and agrees to sign.

Children ' s conditions are complicated and volatile, and physical conditions differ individually. Unpredictable allergies, complications and nosocomial infections may occur, or the disease may relapse and persist during treatment.

Statement of the Patient' s Side

The legal guardian has been fully informed of all the above information.

Guardian' s Signature:

Relationship to Patient:

Date:

Attending Physician' s Signature:

Date:

Record 2

Basic Information

Name:

Department: Neonatology

Ward: Ward 24

Bed No.: 2423

Hospital Admission No.:

Patient: Male, 3 months and 6 days old

Time: 20:25, May 30, 2022

Location: Ward 24

Communication Contents (Including Condition, Diagnosis, Treatment, Prognosis, Risks, Complications, Medical Expenses, etc.)

1. Preliminary diagnosis of the child: Bronchopneumonia.
2. Post-admission examinations: Routine blood, urine and stool tests, coagulation panel, bilateral blood culture, blood gas and electrolyte analysis, myocardial triple indicators, procalcitonin, heparin-binding protein, sputum culture, respiratory pathogen antibody test, hepatitis B serology, pre-transfusion screening, HBV-DNA, cranial CT, ultrasound, blood and urine genetic metabolic testing, etc.
3. After completing relevant examinations, the child is notified as critically ill. Initial anti-infection treatment with Latamoxef is administered after penicillin skin test. Oral medications including Clostridium Butyricum combined live bacteria powder, Vitamin AD and Vitamin D are given, together with formula feeding and intravenous fluid resuscitation and other comprehensive therapies.
4. Condition assessment: The child presented with cough and tachypnea during this illness. External hospital tests showed significantly elevated inflammatory markers and obvious exudation on chest radiograph. Physical examination on admission revealed slightly increased muscle tension, backward head tilt and left downward deviation of the mouth corner when crying. Neurological diseases and inherited metabolic disorders cannot be excluded; lumbar puncture may be performed for further diagnosis if necessary. Given the young age and rapid disease progression, a critical illness notice is issued. The family is informed of potential risks including recurrent fever, intractable high fever, aggravated cough, dyspnea, decreased pulse oxygen saturation, feeding intolerance, vomiting, diarrhea and

water-electrolyte disturbance. Severe complications such as convulsions, DIC, shock and cardiopulmonary arrest may occur, and transfer to ICU may be required. Long hospitalization, high medical costs and difficult treatment are expected. Even after active rescue and treatment, multi-system sequelae may remain. Medical expenses are closely related to disease changes.

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All the above contents have been communicated to the guardian, who fully understands and agrees to sign.

Children ' s conditions are complicated and volatile, and physical conditions differ individually. Unpredictable allergies, complications and nosocomial infections may occur, or the disease may relapse and persist during treatment.

Statement of the Patient ' s Side

The legal guardian has been fully informed of all the above information.

Guardian ' s Signature: Attending Physician ' s Signature:

Relationship to Patient:

Date: Date:

Record 3

Basic Information

Name:

Department: Neonatal Intensive Care Unit (NICU)

Ward: Ward 23

Bed No.: 2336

Hospital Admission No.:

Patient: Female, 1 hour and 57 minutes after birth

Time: 12:18, July 11, 2025

Location: Ward 23

Communication Contents (Including Condition, Diagnosis, Treatment, Prognosis, Risks, Complications, Medical Expenses, etc.)

1. Current diagnoses of the child:

(1) Preterm infant (gestational age ≥ 24 weeks and < 28 weeks)

(2) Severe birth asphyxia

(3) Neonatal respiratory distress syndrome

(4) Very low birth weight infant (1000 – 1249g)

(5) Neonatal respiratory failure

(6) Neonatal pneumonia

(7) Perinatal pulmonary hemorrhage

(8) Small twin of twins

2. Post-admission examinations: Routine blood, urine and stool tests, blood gas and electrolyte analysis, reticulocyte count, complete blood count, pre-transfusion screening, hepatitis B serology, TORCH screening, blood type, procalcitonin, urine CMV-DNA detection, unilateral blood culture, blood gas and electrolyte analysis, comprehensive biochemistry, serum calcium and magnesium, mycoplasma/chlamydia nucleic acid test, organ ultrasound, chest radiograph, echocardiogram, etc.

3. The child is notified as critically ill after admission, placed in an incubator with continuous cardiac and pulse oximetry monitoring, and supported by invasive mechanical ventilation. As a preterm infant with poor immune function and suspected maternal intrauterine infection, infection risk requires close monitoring. Anti-infection treatment with Latamoxef and penicillin is initiated. Bilateral lower limb cyanosis is observed; batroxobin, coagulation factors and plasma transfusion are given to improve coagulation status,

combined with intravenous supplementation and other symptomatic supportive care. Treatment plans will be adjusted timely according to disease progression and examination results.

4. Condition assessment: The infant is a preterm neonate of 27⁺⁶ weeks gestation with very low birth weight, presenting with tachypnea and emergency resuscitation history after birth. Due to young gestational age and rapid disease deterioration, a critical illness notice is issued. The family is informed of possible in-hospital risks including dyspnea, fever, tachypnea, declined pulse oxygen saturation, infection, electrolyte disturbance and convulsions. Severe cases may develop respiratory failure, heart failure, DIC, cardiopulmonary arrest and shock, which can be life-threatening. Potential complications related to prematurity include:

(1) Immature lung development: Neonatal respiratory distress syndrome, and subsequent bronchopulmonary dysplasia with permanent oxygen dependence.

(2) Immature gastrointestinal tract: Feeding difficulties such as vomiting and abdominal distension, even necrotizing enterocolitis.

(3) High infection risk: Extremely weak immunity leads to high susceptibility to pulmonary infection, severe bacterial/viral infection and sepsis. Nosocomial infection is common and hard to control.

(4) Prematurity itself is a pathological state, with potential developmental and inherited metabolic disorders.

(5) Bleeding tendency: Imperfect coagulation system may cause intracranial or visceral hemorrhage.

(6) Adverse reactions of oxygen therapy: Bronchopulmonary dysplasia and retinopathy of prematurity.

(7) Encephalopathy: Immature brain tissue may lead to intracranial hemorrhage, brain injury and long-term sequelae such as cerebral palsy. Guardians are required to understand and cooperate actively.

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Statement of the Patient ' s Side

The legal guardian has been fully informed of all the above information.

Guardian ' s Signature: Attending Physician ' s Signature:

Relationship to Patient:

Date: Date: