

Vomiting

Pediatric After-Hours Version

- DEFINITION -

- * Vomiting is the forceful emptying (throwing up) of a large portion of the stomach's contents through the mouth
- * Retching (dry heaves) describes the rhythmic contractions of the abdominal and intercostal muscles without producing any vomit
- * Nausea and abdominal discomfort usually precede each bout of vomiting
- * Vomiting and diarrhea together is also covered by this Vomiting guideline (EXCEPTION: if vomiting is minimal (1 or 2 times), use the Diarrhea guideline)

- INITIAL ASSESSMENT QUESTIONS -

1. SEVERITY: "How many times has he vomited today?" "Over how many hours?"
 - MILD: 1-4 times/day
 - MODERATE: 5-10 times/day
 - SEVERE: > 10 times/day, vomits everything or nearly everything
2. ONSET: "When did the vomiting begin?"
3. FLUIDS: "What fluids has he kept down today?" "What fluids or food has he vomited up today?"
4. DIARRHEA: "Is there any diarrhea?" If so, ask: "How many times today?"
5. HYDRATION STATUS: "Any signs of dehydration?" (eg dry mouth [not only dry lips], no tears, sunken soft spot) "When did he last urinate?"
6. CHILD'S APPEARANCE: "How does your child look?" "What is he doing right now?"
7. CONTACTS: "Is there anyone else in the family with the same symptoms?"
8. CAUSE: "What do you think is causing your child's vomiting?"

- BACKGROUND INFORMATION -

CAUSES

- * Main cause: stomach infection (gastritis) from a stomach virus (e.g., Rotavirus). In gastroenteritis, the illness starts with vomiting but diarrhea follows within 12-24 hours.
- * If vomiting persists as an isolated symptom (without diarrhea) beyond 24 hours, more serious causes must be considered. Examples are intussusception, poisoning, meningitis, increased intracranial pressure, hepatitis, or pyelonephritis.
- * Vomiting triggered by hard coughing. Common in children with reflux.

RETURN TO SCHOOL

- * Your child can return to day care or school after vomiting and fever are gone.

REFLUX VERSUS VOMITING: AVOIDING OVER-REFERRAL

- * REFLUX: The following findings suggest reflux (spitting up): infant previously diagnosed with reflux, onset early in life (85% by 7 days of life, with a delayed onset more common in breastfed newborns), present for several days or weeks, no discomfort during reflux, no diarrhea, hungry, looks well and acts happy.
- * VOMITING: The following findings suggest vomiting: uncomfortable during vomiting, new symptom starting today or yesterday, associated diarrhea, projectile or forceful vomiting, looks or acts sick.
- * VOLUME: Vomiting usually brings up a large volume of stomach contents. The vomiting is usually forceful and the child is usually uncomfortable. Spitting up (reflux) usually involves smaller amounts. However, with gastroesophageal reflux, the volume of reflux can fluctuate. The amount can become

large if the child is wearing a tight diaper, is held in the horizontal position, or the size of the feeding was particularly large. Therefore, the amount is not that helpful to distinguishing between these 2 entities.

During the first month of life, newborns with true vomiting are seen immediately because the causes can be serious, including sepsis. Therefore, it's important to distinguish between reflux and true vomiting to prevent under- and over-referral.

VOMITING: MOST FREQUENT PEDIATRIC AFTER-HOURS CALL

- * Every year, vomiting comes in first in call frequency. This can be explained by the following:
- * Before vomiting, children are apprehensive and incapacitated.
- * During vomiting, children are miserable.
- * Parents remember how badly vomiting has made them feel.
- * Parents often hope there is a medicine to stop the vomiting. Unfortunately, there is no safe medicine.
- * All parents want to be sure they are treating the vomiting correctly. Hence, the importance of the care advice provided.

SEVERITY OF VOMITING

The following is an arbitrary attempt to clarify vomiting by risk for dehydration:

- * MILD: 1 - 4 times/day
- * MODERATE: 5 - 10 times/day
- * SEVERE: Vomits everything or nearly everything
- * Severity relates even more to the length of time that the particular level of vomiting has persisted. At the beginning of a vomiting illness (especially following food poisoning), it's common for a child to vomit everything for 3 or 4 hours and then become stable with mild or moderate vomiting.

BILE-STAINED (BILIOUS) VOMITING

- * Bilious vomiting in young infants or newborns can indicate GI obstruction (e.g., malrotation, volvulus, etc). This can be a surgical emergency.
- * In this guideline, all children < 6 months of age with bilious vomiting are referred in immediately. So are children of any age with bile-stained vomitus combined with constant abdominal pain or abdominal distention.
- * Bile-stained vomitus can also be seen in gastroenteritis or food poisoning, especially with repeated vomiting or retching. Repeated vomiting often empties the duodenum as well as the stomach.
- * Referring in all children with this symptom results in over-referral.

DETECTING BILE IN VOMITUS

- * Bile in vomitus is usually bright yellow-mustard color.
- * Occasionally it is bright green.
- * It usually is in a liquid state.
- * If the yellow coloring is in a glob of mucus, it's usually from the nose ("snot") and has been swallowed.

GIVING FLUIDS VERSUS NPO FOR VOMITING

Sometimes children vomit everything that is offered to them, including ORS and water. Other children are so nauseated they don't want to swallow anything. If vomiting is the only symptom (no associated diarrhea), it is safe to rest the stomach completely for 1 or 2 hours. It's unusual to become rapidly dehydrated from vomiting alone. Some children who begin vomiting at bedtime will

vomit several times during the night without having any fluid intake, but still be hydrated with very concentrated urine in the morning.

The reason that this guideline instructs callers not to use NPO is that recommending it in selected circumstances can be confusing to some parents and contribute to dehydration in children who develop watery diarrhea with their vomiting. In addition, during the brief time that fluid is retained in the stomach, some of it is absorbed and this can help prevent dehydration. The literature demonstrates that we can feed most children through a vomiting and/or diarrhea illness.

PEPTOBISMOL

Peptobismol (bismuth subsalicylate) is sometimes used for diarrhea. It has no proven benefit for treating vomiting. The concern that the salicylate in Peptobismol might cause Reye's syndrome has never been documented. Therefore, we should not needlessly burden parents with this concern.

DEHYDRATION: ESTIMATION BY TELEPHONE

SUMMARY

- * A child who is alert, happy and playful is NOT dehydrated.
- * Diminished urination occurs early in the process of dehydration (Gorelick 1997). Decreased urination (no urine in more than 12 hours) alone, however, should not be used to diagnose dehydration if other findings of dehydration are absent. (Exception: no urine > 12 hours and can't urinate now). As an isolated symptom, decreased urination only has a 17% predication for dehydration. In general, children with normal urine output are NOT dehydrated. (Exception: renal disease, diabetes mellitus or insipidus).
- * A subset of 4 factors - capillary refill > 2 seconds, absent tears, dry mucous membranes, and ill general appearance - best predicted dehydration. The presence of any 2 factors correlated with a 5% deficit and the presence of any 3 factors with a 10% deficit (Gorelick 1997). In another study, decreased skin turgor (tenting) was a good predictor of dehydration and the duration of tenting correlated closely with the extent of dehydration (Armon 2000). However, this sign is usually difficult to assess by telephone.
- * In general, mild diarrhea, mild vomiting or a mild decrease in fluid intake does not cause dehydration.

MILD DEHYDRATION: 3-5% weight loss

- * Urine Production: slightly decreased
- * Mucous Membranes: normal
- * Tears: present
- * Anterior Fontanelle: normal
- * Mental Status: normal
- * Capillary Refill: < 2 sec
- * Treatment: can usually treat with ORS at home

MODERATE DEHYDRATION: 5-10% weight loss

- * Urine Production: none for > 8 hrs. for infants, > 12 hrs. for older children
- * Mucous Membranes: dry inside of mouth
- * Tears: decreased
- * Anterior Fontanelle: normal to sunken
- * Mental Status: irritable
- * Capillary Refill: > 2 sec
- * Treatment: must be seen

SEVERE DEHYDRATION: >10% weight loss

- * Urine Production: very decreased or absent
- * Mucous Membranes: very dry inside of mouth
- * Tears: absent, sunken eyes
- * Anterior Fontanelle: sunken
- * Mental Status: very irritable to lethargic
- * Capillary Refill: > 2-4 sec
- * Treatment: must be seen. If signs of shock, activate EMS (911)

SIGNS OF SHOCK

- * Extremities (esp. hands and feet) are bluish or gray
- * Extremities are cold
- * Child too weak to stand or very dizzy when tries to stand
- * Child is difficult to awaken or unresponsive
- * Pulse is rapid and weak
- * Capillary refill > 4 seconds

FIRST AID

FIRST AID ADVICE FOR SHOCK: Lie down with the feet elevated.

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SEARCH WORDS

ABDOMEN

BARF

BILE

BILIOUS

BLOOD IN VOMITUS

DEHYDRATED

DEHYDRATION

DIARRHEA

DRY HEAVES

EMESIS

FOOD POISONING

GASTRITIS

IRRITATED STOMACH

NAUSEA

NAUSEATED

NAUSEOUS

PEDIATRIC

RETCHING

SHOCK

SPITTING UP

STOMACH

STOMACH VIRUS

THREW UP

THROWING UP

VIRAL GASTRITIS

VOMIT

VOMITED

VOMITING

VOMITING BILE

VOMITING BLOOD

VOMITUS

- TRIAGE -

Call EMS 911 Now

Shock suspected (very weak, limp, not moving, too weak to stand, pale cool skin)

FIRST AID: have child lie down with feet elevated

CA: 50, 12

Sounds like a life-threatening emergency to the triager

CA: 50, 12

See More Appropriate Guideline

[1] Previously diagnosed reflux AND [2] volume increased today AND [3] infant appears well

Go to Guideline: Spitting Up (Reflux) (Pediatric)

[1] Age of onset < 1 month old AND [2] sounds like reflux or spitting up

Go to Guideline: Spitting Up (Reflux) (Pediatric)

Vomiting only occurs after taking a medicine

Go to Guideline: Vomiting On Meds (Pediatric)

Vomiting occurs only while coughing

Go to Guideline: Cough (Pediatric)

Diarrhea is the main symptom (vomiting is minimal)

Go to Guideline: Diarrhea (Pediatric)

[1] Age > 12 months AND [3] ate spoiled food within the last 12 hours

Go to Guideline: Food Poisoning (Pediatric)

[1] Severe headache AND [2] history of migraines

Go to Guideline: Headache (Pediatric)

Go to ED Now

Child sounds severely dehydrated to the triager

CA: 51, 21, 12

[1] Blood (red or coffee grounds color) in the vomit AND [2] not from a nosebleed (EXCEPTION: few streaks and only occurs once)

R/O: peptic ulcer, esophagitis, Mallory-Weiss tear

CA: 51, 16, 21, 12

Difficult to awaken

R/O: encephalitis, Reye's syndrome, intussusception, overdose

CA: 51, 20, 12

Confused (delirious) when awake

R/O: encephalitis, meningitis

CA: 51, 12

Neurological symptoms (eg stiff neck, bulging soft spot)

R/O: meningitis

CA: 51, 12

Poisoning suspected (with a medicine, plant or other chemical)

CA: 51, 19, 12

[1] Age < 12 weeks AND [2] fever > 100.4 F (38.0 C) rectally

R/O: sepsis

CA: 51, 17, 21, 12

Go to ED Now (or PCP triage)

[1] Newborn (< 1 month old) AND [2] starts to look or act sick in any way

R/O: sepsis, NEC, adrenal insufficiency

CA: 52, 12

[1] Bile (bright yellow or green color) in the vomit AND [2] constant abdominal pain not relieved by vomiting OR very swollen abdomen

R/O: GI obstruction

CA: 52, 20, 12

[1] Age < 6 months AND [2] bile (bright yellow or green color) in the vomit

R/O: GI obstruction, necrotizing enterocolitis

CA: 52, 20, 12

[1] SEVERE abdominal pain (when not vomiting) AND [2] present > 1 hour

R/O: bowel obstruction

CA: 52, 20, 12

Intussusception suspected (brief attacks of severe abdominal pain/crying suddenly switching to 2-10 minute periods of quiet) (age usually < 3 years)

CA: 52, 20, 12

[1] Dehydration suspected AND [2] age < 1 year (Signs: no urine > 8 hours AND very dry mouth, no tears, sunken soft spot, ill appearing, etc.)

CA: 52, 12

[1] Dehydration suspected AND [2] age > 1 year (Signs: no urine > 12 hours AND very dry mouth, no tears, ill appearing, etc.)

CA: 52, 12

[1] Severe headache AND [2] persists > 2 hours AND [3] no previous migraine

R/O: *increased intracranial pressure, 1st migraine headache*

CA: 52, 20, 12

[1] Fever AND [2] > 105 F (40.6 C) by any route OR axillary > 104 F (40 C)

R/O: *serious bacterial infection*

CA: 52, 18, 21, 12

High-risk child (e.g. diabetes mellitus, brain tumor, V-P shunt, previous abdominal surgery, inguinal hernia)

CA: 52, 21, 12

Diabetes suspected (excessive thirst, frequent urination, weight loss, rapid breathing, etc.)

CA: 52, 21, 12

Child sounds very sick or weak to the triager

CA: 52, 21, 12

See Physician within 4 Hours (or PCP triage)

[1] Age < 12 weeks AND [2] vomited 3 or more times in last 24 hours (EXCEPTION: reflux or spitting up)

R/O: *pyloric stenosis, early GI obstruction*

CA: 53, 21, 22, 12

[1] Age < 12 mo AND [2] receiving frequent sips of ORS per guideline AND [3] also has watery diarrhea AND [4] continues to vomit 3 or more times

Reason: *dehydration risk*

CA: 53, 21, 22, 12

1) Receiving frequent sips of ORS per guideline AND [2] SEVERE vomiting (vomiting everything) > 8 hours (> 12 hours for > 6 yo)

CA: 53, 21, 22, 12

[1] Continuous abdominal pain or crying AND [2] persists > 2 hours
(Caution: intermittent abdominal pain improved by vomiting is quite common)

R/O: *early GI obstruction*

CA: 53, 20, 22, 12

[1] Abdominal injury AND [2] in last 3 days

R/O: traumatic pancreatitis, or duodenal hematoma

CA: 53, 20, 22, 12

[1] Recent head injury within 3 days AND [2] vomited 2 or more times (EXCEPTION: [1] minor injury AND [2] diarrhea or fever)

R/O: subdural hematoma

CA: 53, 20, 22, 12

Call PCP Now

Vomiting an essential medicine

CA: 59

See Physician within 24 Hours

Age < 2 years old AND vomiting > 24 hours

(EXCEPTION: (1) MILD vomiting AND (2) associated diarrhea)

CA: 54, 4, 7, 6, 8, 9, 10, 22, 12

Age > 2 years old AND vomiting > 48 hours

(EXCEPTION: (1) MILD vomiting AND (2) associated diarrhea)

CA: 54, 8, 9, 10, 22, 12

Fever present > 3 days (72 hours)

R/O: bacterial cause such as UTI, strep pharyngitis

CA: 54, 10, 4, 7, 6, 8, 9, 22, 12

See PCP When Office is Open (within 3 days)

[1] MILD vomiting with diarrhea AND [2] persists > 1 week

CA: 55, 4, 7, 8, 9, 10, 15, 11, 12

See PCP within 2 Weeks

Vomiting is a chronic problem (recurrent or ongoing AND present > 4 weeks)

R/O: cyclic vomiting, peptic ulcer

CA: 56, 23, 4, 7, 6, 8, 9, 10, 22, 12

Home Care

[1] SEVERE vomiting (> 10 times per day OR vomits everything) BUT [2] hydrated

Reason: will usually pass and all triage questions negative

CA: 58, 1, 3, 4, 7, 6, 8, 9, 10, 2, 12

[1] MILD-MODERATE vomiting AND [2] age < 1 year old

Reason: probably viral gastritis and all triage questions negative

CA: 58, 13, 4, 7, 6, 10, 14, 15, 5, 12

[1] MILD-MODERATE vomiting AND [2] age > 1 year old

Reason: probably viral gastritis and all triage questions negative

CA: 58, 13, 8, 9, 10, 14, 15, 11, 12

[1] MILD vomiting (1-4 times/day) with diarrhea AND [2] present < 1 week AND [3] age < 1 year old
(all triage questions negative)

CA: 58, 4, 7, 6, 15, 5, 12

[1] MILD vomiting (1-4 times/day) with diarrhea AND [2] present < 1 week AND [3] age > 1 year old
(all triage questions negative)

CA: 58, 8, 9, 15, 11, 12

- CARE ADVICE (CA) -

1. REASSURANCE:
 - Sometimes children vomit almost everything for 3 or 4 hours, even if given small amounts. However, some fluid is being absorbed and this will help prevent dehydration.
 - From what you've told me, your child is well hydrated at this time.
 - So continue offering fluids (Avoid: NPO)
2. CALL BACK IF:
 - Signs of dehydration occur
 - Vomits everything > 8 hours while receiving ORS correctly (> 12 hours for > 6 years old)
 - Blood in vomit
 - Your child becomes worse
3. SLEEP:
 - Encourage your child to rest or go to sleep for a few hours. (Reason: sleep often empties the stomach and relieves the need to vomit).
 - When your child awakens, again offer small amounts of clear fluids every 5 minutes.
 - If your child also has watery diarrhea, awaken after 3 hours for clear fluids, if she doesn't self-awaken.
4. FOR BOTTLEFED INFANTS (< 1 year old), offer Oral Rehydration Solution (ORS) (e.g., Pedialyte or the store brand) is a special electrolyte solution that can prevent dehydration. It's readily available in supermarkets and drug stores.
 - For vomiting once or twice, offer 1/2 strength formula for 2 feedings, then regular formula.
 - For vomiting > 2 times within last 2 hours, offer ORS for 8 hours.
 - Spoon feed small amounts: 1-2 teaspoons (5-10 ml) every 5 minutes.
 - After 4 hours without vomiting, double the amount.
 - After 8 hours without vomiting, return to regular formula.
5. CALL BACK IF:
 - Vomiting everything > 8 hours
 - Isolated vomiting persists > 24 hours
 - Mild vomiting associated with diarrhea persists > 1 week
 - Signs of dehydration
 - Your child becomes worse
6. SOLIDS (after 8 hours without vomiting):
 - For infants > 4 months old, also return to cereal, strained bananas, etc.
 - Normal diet OK in 24-48 hours.

7. FOR BREASTFED INFANTS, reduce the amount per feeding.
 - If vomits once or twice, nurse 1 side q 1 to 2 hours.
 - If vomits > 2 times within last 2 hours, nurse for 4 to 5 minutes, q 30 to 60 minutes.
 - If continues to vomit, switch to ORS for 4 hours.
 - Spoon feed small amounts of ORS: 1-2 teaspoons (5-10 ml) every 5 minutes.
 - After 4 hours of ORS, return to breastfeeding. Start with small feedings of 5 minutes every 30 minutes and increase as tolerated.
8. FOR OLDER CHILDREN (> 1 year old) offer clear fluids in small amounts for 8 hours.
 - Water or ice chips are best for vomiting in older children (Reason: water is directly absorbed across the stomach wall) (Exception: also has diarrhea)
 - ORS: Vomiting with watery diarrhea needs ORS. If refuses ORS, use 1/2-strength Gatorade. Also, use ORS if child vomits water.
 - Give small amounts: 2-3 teaspoons (10-15 ml) q 5 minutes.
 - Other options: 1/2 strength flat lemon-lime soda, Popsicles or ORS frozen pops
 - After 4 hours without vomiting, double the amount.
9. SOLIDS: For older children (> 1 year old), add bland foods after 8 hours without vomiting.
 - Add bland foods (any complex carbohydrates) for 24 hours.
 - Start with saltine crackers, white bread, cereals, rice, mashed potatoes, etc.
 - Normal diet OK in 24-48 hours.
10. AVOID MEDS:
 - Discontinue all nonessential medicines for 8 hours. (Reason: usually makes vomiting worse.) (Avoid ibuprofen, which can cause gastritis)
 - Consider acetaminophen suppositories (same as oral dose) if the fever needs treatment (over 102 F or 39 C and causing discomfort).
 - Call if child vomiting an essential medicine.
11. CALL BACK IF:
 - Vomiting everything > 8 hours (> 12 hours for > 6 years)
 - Isolated vomiting persists > 24 hours (> 48 hours if age > 2 years)
 - Mild vomiting associated with diarrhea persists > 1 week
 - Signs of dehydration
 - Your child becomes worse
12. CARE ADVICE per Vomiting (Pediatric) guideline.
13. REASSURANCE:
 - Most vomiting is caused by a viral infection of the stomach or mild food poisoning.
 - Vomiting is the body's way of protecting the lower GI tract.
 - Fortunately, vomiting illnesses are usually brief.
14. EXPECTED COURSE: Vomiting from viral gastritis usually stops in 12 to 24 hours. If diarrhea is present, it usually continues for several days.
CONTAGIOUSNESS: Your child can return to daycare or school after vomiting and fever are gone.

15. For MILD DIARRHEA, follow the care advice for vomiting. Don't do anything special for the diarrhea.
16. SAMPLE: Bring in a sample of the "bloody" material. (Reason: for testing.)
17. FEVER AND < 3 MONTHS OLD: Don't give any acetaminophen before being seen. Need accurate documentation of temperature in medical setting to decide if fever is really present. (Reason: may require septic work-up)
18. FEVER: Give acetaminophen to bring down the fever. An acetaminophen suppository would be preferable.
19. SAMPLE: For possible poisoning, bring in any material that's vomited. (Reason: for testing.)
20. NPO: Do not allow any eating, drinking or oral medicines. (Reason: condition may need surgery and general anesthesia)
21. ORS: Give small amounts (1 tsp) of ORS (e.g. Pedialyte) every 5 minutes until seen. If > 1 year old, can use water or ORS every 5 minutes.
22. CALL BACK IF:
 - Your child becomes worse
23. VOMITING DIARY: Keep a diary of your child's vomiting: Include the date, time, place, and what your child ate in the previous 2 hours. (Reason: try to find some of the triggers.)
50. CALL EMS 911 NOW: Your child needs immediate medical attention. You need to hang up and call 911 (or an ambulance). (Triager Discretion: I'll call you back in a few minutes to be sure you were able to reach them.)
51. GO TO ED NOW: Your child needs to be seen in the Emergency Department immediately. Go to the ER at _____ Hospital. Leave now. Drive carefully.
52. GO TO ED NOW (or PCP triage)
 - IF NO PCP TRIAGE: Your child needs to be seen within the next hour. Go to the ER/UCC at _____ Hospital. Leave as soon as you can.
 - IF PCP TRIAGE REQUIRED: Your child may need to be seen. Your doctor will want to talk with you to decide what's best. I'll page him now. If you haven't heard from the on-call doctor within 30 minutes, or your child becomes worse, go directly to the ER/UCC) at _____ Hospital.
53. SEE PHYSICIAN WITHIN 4 HOURS (or PCP triage)
 - IF NO PCP TRIAGE: Your child needs to be seen. Go to _____ (ED/UCC or office if it will be open) within the next 3 or 4 hours. Go sooner if your child becomes worse.
 - IF PCP TRIAGE REQUIRED: Your child may need to be seen. Your doctor will want to talk with you to decide what's best. I'll page him now. If you haven't heard from the on-call doctor within 30 minutes, call again. (Note: If PCP can't be reached, send to ED/UCC or office.)

54. **SEE PHYSICIAN WITHIN 24 HOURS**
IF OFFICE WILL BE OPEN: Your child needs to be examined within the next 24 hours. Call your child's doctor when the office opens, and make an appointment.
IF OFFICE WILL BE CLOSED AND NO PCP TRIAGE:
Your child needs to be examined within the next 24 hours. Go to _____ at your convenience.
IF OFFICE WILL BE CLOSED AND PCP TRIAGE REQUIRED:
Your child may need to be seen within the next 24 hours. Your doctor will want to talk with you to decide what's best. I'll page him now. (EXCEPTION: from 10 pm to 7 am. Since this isn't serious, we'll hold the page until morning.)
55. **SEE PCP WITHIN 3 DAYS:** Your child needs to be examined within 2 or 3 days. Call your child's doctor during regular office hours and make an appointment.
56. **SEE PCP WITHIN 2 WEEKS:** Your child needs an evaluation for this ongoing problem within the next 2 weeks. Call your child's doctor during regular office hours and make an appointment.
57. **FOLLOW-UP:** Discuss _____ with your child's doctor at the next regular office visit (Call sooner if you become more concerned.)
58. **HOME CARE:** You should be able to treat this at home.
59. **CALL PCP NOW:** You need to discuss this with your child's doctor. I'll page him now. If you haven't heard from the on-call doctor within 30 minutes, call again.
60. **CALL PCP WITHIN 24 HOURS:** You need to discuss this with your child's doctor within the next 24 hours.
IF OFFICE WILL BE OPEN: Call the office when it opens tomorrow morning.
IF OFFICE WILL BE CLOSED: I'll page him now. (EXCEPTION: from 9 pm to 9 am. Since this isn't urgent, we'll hold the page until morning.)
61. **CALL PCP WHEN OFFICE IS OPEN:** You need to discuss this with your child's doctor within the next few days. Call him/her during regular office hours.

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