

EMERGENCY DEPARTMENT NURSING FLOW SHEET

Date	Mode of Arrival <input type="checkbox"/> Walk <input type="checkbox"/> W/C <input type="checkbox"/> Gurney <input type="checkbox"/> Carried <input type="checkbox"/> Police	Medic Unit	Pain Scale: 0 1 2 3 4 5 6 7 8 9 10	PMD:	TRIAGE CATEGORY I II III IV V
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RAPID ASSESSMENT

Does the patient have an infection or suspicion of infection? Yes No Is patient on antibiotics (not prophylaxis?) Yes No

CHIEF COMPLAINT:

AIRWAY <input type="checkbox"/> Patent <input type="checkbox"/> Impaired	BREATHING <input type="checkbox"/> Unlabored <input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Deep	CIRCULATION <input type="checkbox"/> Palpable pulse <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Jaundice <input type="checkbox"/> Cyanotic	NEURO <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Unresponsive <input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Garbled	Time of Assessment: _____ Rapid Triage RN Signature: _____
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TEMP oral	PULSE	RESP	BP	Rt	Sat	Rm	Air	RA	ACCUCHECK	WEIGHT - KG	STATED	ACTUAL	Ht	IMMUNIZATION	LMP	ROOM	TIME	PLACED IN RM BY	
rectal				Lt															

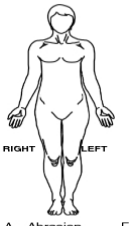
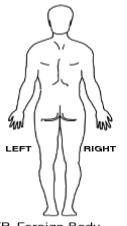

ALLERGIES: (Drug / Reaction) NKDA

Glasgow Coma Scale Best Eye Opening 4 - Spontaneous 3 - To voice Best Verbal 5 - Oriented (Coos, babbles) 4 - Confused (cries) 3 - Inappr words (screams/grunts) Best Motor 6 - Obeys commands (Spont.) 5 - Localizes pain 4 - Withdrawal	PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10 On Arrival _____ PAIN: Onset _____ Location: _____	<input type="checkbox"/> See Medication Reconciliation Form HISTORY <input type="checkbox"/> None <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Sz <input type="checkbox"/> CVA <input type="checkbox"/> ETOH <input type="checkbox"/> Psych <input type="checkbox"/> Cardiac <input type="checkbox"/> COPD <input type="checkbox"/> Dialysis <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Last Tx _____ <input type="checkbox"/> HTN <input type="checkbox"/> GI <input type="checkbox"/> Unknown <input type="checkbox"/> Smoker <input type="checkbox"/> GU <input type="checkbox"/> Migraines <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Breast Feeding <input type="checkbox"/> CA <input type="checkbox"/> Thyroid <input type="checkbox"/> Other _____
INTERVENTION <input type="checkbox"/> Ice <input type="checkbox"/> Elevate <input type="checkbox"/> Soft splint <input type="checkbox"/> Dressing applied <input type="checkbox"/> Bleeding controlled <input type="checkbox"/> Hard Collar placed <input type="checkbox"/> Acetaminophen <input type="checkbox"/> NPO instruction given <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Respiratory Precautions Initiated		
VISUAL ACUITY LT RT BOTH CORRECTED <input type="checkbox"/> YES <input type="checkbox"/> NO		

PRE HOSPITAL CARE VS: P _____ R _____ BP _____ SPO2 _____ /O2 _____ L/min _____ Cardiac Rhythm _____ C-spine precautions <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Assist <input type="checkbox"/> Yes <input type="checkbox"/> No ETT <input type="checkbox"/> Yes <input type="checkbox"/> No CPR <input type="checkbox"/> Yes <input type="checkbox"/> No Accucheck _____ Medication/Treatments _____ IV <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Gauge _____ Site _____	SKIN SIGNS <input type="checkbox"/> Normal, Warm, Dry <input type="checkbox"/> Cyanotic <input type="checkbox"/> Clammy <input type="checkbox"/> Pale <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Jaundice <input type="checkbox"/> Hot <input type="checkbox"/> Flushed <input type="checkbox"/> Cool	GAIT: <input type="checkbox"/> Steady <input type="checkbox"/> W/Crutches/Cane <input type="checkbox"/> In W/C <input type="checkbox"/> Not Observed <input type="checkbox"/> _____ RME MD/PA/NP: _____ Time of Assessment _____ Comprehensive Triage/Assessment RN Signature _____
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NEURO <input type="checkbox"/> ALERT <input type="checkbox"/> RESTLESS <input type="checkbox"/> ORIENTED <input type="checkbox"/> COMBATIVE <input type="checkbox"/> COOPERATIVE <input type="checkbox"/> CRYING <input type="checkbox"/> CLEAR <input type="checkbox"/> SLURRED <input type="checkbox"/> UNCONSCIOUS <input type="checkbox"/> GARBLED <input type="checkbox"/> SEE NEURO FLOW SHEET <input type="checkbox"/> PUPILS <input type="checkbox"/> N/A Size: Rt _____ Lt _____ Reactivity: Rt _____ Lt _____	EXTREMITY C.S.M. <input type="checkbox"/> N/A CAPILLARY REFILL Rt Arm _____ Rt Leg _____ Lt Arm _____ Lt Leg _____ SENSATION Rt Arm _____ Rt Leg _____ Lt Arm _____ Lt Leg _____ MOVEMENT / STRENGTH Rt Arm _____ Rt Leg _____ Lt Arm _____ Lt Leg _____ W - weak D - delayed over 2 sec. A - absent N - numbness T - tingling P - painful B - brisk Ir - irregular I - Intact	CARDIOVASCULAR <input type="checkbox"/> N/A PULSES <input type="checkbox"/> STRONG <input type="checkbox"/> JVD <input type="checkbox"/> REGULAR <input type="checkbox"/> PEDAL EDEMA <input type="checkbox"/> IRREGULAR PEDIATRICS CAPILLARY REFILL _____ FONTANEL _____ # OF WET DIAPERS _____ x 24 TEARS _____ MUCOUS MEMBRANES _____	RESPIRATORY <input type="checkbox"/> N/A <input type="checkbox"/> SYMMETRICAL <input type="checkbox"/> ASYMMETRICAL RESPIRATIONS LUNG SOUNDS <input type="checkbox"/> UNLABORED <input type="checkbox"/> CLEAR <input type="checkbox"/> RT <input type="checkbox"/> LABORED <input type="checkbox"/> WHEEZES <input type="checkbox"/> LT <input type="checkbox"/> SHALLOW <input type="checkbox"/> RALES <input type="checkbox"/> <input type="checkbox"/> DEEP <input type="checkbox"/> RHONCHI <input type="checkbox"/> <input type="checkbox"/> RETRACTION <input type="checkbox"/> DIMINISHED <input type="checkbox"/> <input type="checkbox"/> NASAL FLARING <input type="checkbox"/> ACCESSORY MUSCLE USE <input type="checkbox"/> ABSENT <input type="checkbox"/> <input type="checkbox"/> PAINFUL <input type="checkbox"/> COUGH <input type="checkbox"/> ABSENT <input type="checkbox"/> SPUTUM COLOR <input type="checkbox"/> MECHANICAL/SUPPORTED
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GI / GU <input type="checkbox"/> N/A ABDOMEN <input type="checkbox"/> UNREMARKABLE <input type="checkbox"/> SOFT <input type="checkbox"/> FIRM <input type="checkbox"/> DISTENDED <input type="checkbox"/> TENDER <input type="checkbox"/> NONTENDER <input type="checkbox"/> PAINFUL <input type="checkbox"/> MASSES <input type="checkbox"/> RIGID <input type="checkbox"/> REBOUND <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING x _____ <input type="checkbox"/> DIARRHEA x _____ BOWEL SOUNDS <input type="checkbox"/> PRESENT <input type="checkbox"/> ABSENT <input type="checkbox"/> HYPOACTIVE <input type="checkbox"/> HYPERACTIVE	<input type="checkbox"/> N/A INCONTINENCE <input type="checkbox"/> BOWEL <input type="checkbox"/> BLADDER <input type="checkbox"/> CATHETER PRESENT GENITALS <input type="checkbox"/> DISCHARGE: COLOR _____ <input type="checkbox"/> BLEEDING _____ MAXI PAD/____ HR _____ MINI PAD/____ HR <input type="checkbox"/> TAMPON/____ HR <input type="checkbox"/> OTHER _____ Gravida _____ Para _____ TAB _____ SAB _____ EDC _____ FHT _____ <input type="checkbox"/> Dysuria <input type="checkbox"/> Hematuria LAST BM _____
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SKIN INTEGRITY 		
A - Abrasion B - Burns C - Redness D - Deformity E - Ecchymosis F - Edema	FB - Foreign Body H - Hematoma P - Pain/Tender L - Laceration PW - Puncture Wound R - Rash	S - Swelling 1 - Stage I 2 - Stage II 3 - Stage III 4 - Stage IV O - Other

SCREENING TOOL NUTRITION _____ NON-CONTRIBUTORY REFERRAL _____ DOMESTIC VIOLENCE _____ PSYCHOSOCIAL _____ SKIN INTEGRITY _____ EDUCATION _____ COMMUNICATION BARRIER <input type="checkbox"/> INTERPRETER _____ INTERVENTION _____	<input type="checkbox"/> Sepsis/Aspiration screen completed
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ASSESSMENT RN SIGNATURE _____ **Time:** _____
 Assessment completed by RME MD/PA/NP **Time:** _____