

EMERGENCY DEPARTMENT NURSING FLOW SHEET

Name	Room of Admit	Admit Unit	Admit Order	RN#	RN# of Category
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> 100 <input type="checkbox"/> 101 <input type="checkbox"/> 102 <input type="checkbox"/> 103 <input type="checkbox"/> 104 <input type="checkbox"/> 105 <input type="checkbox"/> 106 <input type="checkbox"/> 107 <input type="checkbox"/> 108 <input type="checkbox"/> 109 <input type="checkbox"/> 110				1 2 3 4 5 6 7

RAPID ASSESSMENT

Does the patient have an alteration or suspicion of alteration? Yes No in patient or protection (and judgement) Yes No

CHIEF COMPLAINT:

History <input type="checkbox"/> Present <input type="checkbox"/> Absent	Presentations <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Other	Characteristics <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> Stable	Onset <input type="checkbox"/> Exact <input type="checkbox"/> Approximate <input type="checkbox"/> Unknown <input type="checkbox"/> Time of Day <input type="checkbox"/> Season <input type="checkbox"/> Other	Time of Assessment Rapid Triage RN Signature: _____
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Vital Signs	ECG	Chest X-ray	Lab	Imaging	Other	Other	Other
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ALLERGIES (Drug / Reactions) NONE

Medication Class Name	ALLERGIES	Other Medication Reactions/Adverse Reactions																					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Anti-Bot</td> <td style="width:50%;">Anti-Stroke</td> </tr> <tr> <td><input type="checkbox"/> Botulinum</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Botulinum</td> <td><input type="checkbox"/> Stroke</td> </tr> </table>	Anti-Bot	Anti-Stroke	<input type="checkbox"/> Botulinum	<input type="checkbox"/> Stroke	<input type="checkbox"/> Botulinum	<input type="checkbox"/> Stroke	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Anti-Stroke</td> <td style="width:50%;">Anti-Stroke</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Stroke</td> </tr> </table>	Anti-Stroke	Anti-Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Anti-Stroke</td> <td style="width:33%;">Anti-Stroke</td> <td style="width:33%;">Anti-Stroke</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Stroke</td> </tr> </table>	Anti-Stroke	Anti-Stroke	Anti-Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke
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PHYSICIAN ORDER	PHYSICIAN	PHYSICIAN
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ASSESSMENT	ASSESSMENT	ASSESSMENT	ASSESSMENT
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ASSESSMENT BY SIGNATURE

Assessment completed by third physician Yes No