

**EMERGENCY DEPARTMENT NURSING FLOW SHEET**

Name	Room of Admit	Admit Unit	Room Number	Floor	Nurses Category
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> General <input type="checkbox"/> Cardiac <input type="checkbox"/> Other	<input type="checkbox"/> Trauma <input type="checkbox"/> Other	1 2 3 4 5 6 7 8 9 10		1 2 3 4 5 6 7

**RAPID ASSESSMENT**

Is this the patient from an admission or suspension of admission? Yes No Is patient on probation (and employment)? Yes No

**CHIEF COMPLAINT:**

<b>History</b> <input type="checkbox"/> Present <input type="checkbox"/> Previous	<b>ADMISSION</b> Admission Transfer Return Other	<b>ADMISSION</b> Admission Transfer Return Other	<b>ADMISSION</b> Admission Transfer Return Other	<b>Time of Admission</b> Hours: _____ Minutes: _____ Signatures: _____
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Vital Signs	Temperature	Pulse	Respiration	BP	SpO2	GCS	Pain	Mental Status
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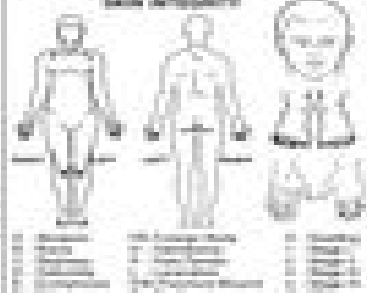
**ALLERGIES (Drug / Reactions)  NONE**

<b>ALLERGIES (Drug / Reactions)</b>	<b>LABORATORY</b>	<b>Other Information</b>
<b>Diagnosis / Chief Complaint</b> Allergy: <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Shellfish Allergy: <input type="checkbox"/> Latex <input type="checkbox"/> Eggs <input type="checkbox"/> Fish Allergy: <input type="checkbox"/> Other _____ Allergy: <input type="checkbox"/> Other _____ Allergy: <input type="checkbox"/> Other _____	<b>LABORATORY</b> Hemoglobin: _____ Hematocrit: _____ WBC: _____ Platelets: _____ Creatinine: _____ BUN: _____ Glucose: _____ Electrolytes: _____ Urinalysis: _____ ECG: _____ CXR: _____ Other: _____	<b>Other Information</b> Insurance: _____ Referral: _____ Other: _____ Other: _____ Other: _____

<b>PHYSICAL EXAM</b>	<b>HEENT</b>	<b>Other Information</b>
Head: _____ Neck: _____ Chest: _____ Abdomen: _____ Extremities: _____ Skin: _____ Neuro: _____ Other: _____	Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Other: _____	Insurance: _____ Referral: _____ Other: _____ Other: _____ Other: _____

<b>IMMUNIZATIONS</b>	<b>ACTIVITY / GAIT</b>	<b>COGNITION / ORIENTATION</b>	<b>NEUROLOGICAL</b>
MMR: _____ Tetanus: _____ Polio: _____ Hib: _____ Pneumonia: _____ Hepatitis: _____ Other: _____	Ambulation: _____ Gait: _____ Balance: _____ Coordination: _____ Reflexes: _____ Strength: _____ Other: _____	Alertness: _____ Attention: _____ Memory: _____ Orientation: _____ Judgment: _____ Problem Solving: _____ Other: _____	Motor: _____ Sensory: _____ Reflexes: _____ Babinski: _____ Romberg: _____ Other: _____

<b>SCREENING TOOLS</b>	<b>SCREENING TOOLS</b>	<b>SCREENING TOOLS</b>	<b>SCREENING TOOLS</b>
Glasgow Coma Scale: _____ NIH Stroke Scale: _____ Barthel ADL: _____ Lawton IADL: _____ Mini-Mental State Exam: _____ Beck Depression Inventory: _____ Other: _____	Glasgow Coma Scale: _____ NIH Stroke Scale: _____ Barthel ADL: _____ Lawton IADL: _____ Mini-Mental State Exam: _____ Beck Depression Inventory: _____ Other: _____	Glasgow Coma Scale: _____ NIH Stroke Scale: _____ Barthel ADL: _____ Lawton IADL: _____ Mini-Mental State Exam: _____ Beck Depression Inventory: _____ Other: _____	Glasgow Coma Scale: _____ NIH Stroke Scale: _____ Barthel ADL: _____ Lawton IADL: _____ Mini-Mental State Exam: _____ Beck Depression Inventory: _____ Other: _____



**ASSESSMENT AND SIGNATURE**

Assessment completed by this admission. Date: \_\_\_\_\_ Time: \_\_\_\_\_