

**EMERGENCY DEPARTMENT NURSING FLOW SHEET**

Name	Room of Admit	Admit Unit	Admit Order	RN#	Nurses 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:**

<b>History</b> <input type="checkbox"/> Present <input type="checkbox"/> Absent	<b>Onset/Duration</b> Onset: _____ Duration: _____	<b>Character</b> Quality: _____ Location: _____ Severity: _____ Timing: _____	<b>Aggravating</b> Factor: _____ Relief: _____	<b>Time of Assessment</b> Rapid Triage RN Signature: _____
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Vital Signs	Pain	Mental Status	Glasgow	LOC	GCS	Pupils	Reflexes	Extremities	Skin	Other
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**ALLERGIES (Drug / Reactions)  NONE**

<b>Medication / Drug Name</b>	<b>ALLERGIC</b>	<b>Other Medication / Administration Route</b>																																			
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**ASSESSMENT RN SIGNATURE**

Assessment completed by third discipline. Time: \_\_\_\_\_