

EMERGENCY DEPARTMENT NURSING FLOW SHEET

Name	Room #	Room Type	Admission Date	Time	Nurse Category
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Adult <input type="checkbox"/> Child	<input type="checkbox"/> General <input type="checkbox"/> Critical <input type="checkbox"/> Trauma	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10		<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> CNA

RAPID ASSESSMENT

Does the patient have an alteration or suspicion of alteration? Yes No in patient or provider (and physician) has for
CHIEF COMPLAINT:

History	Presenting	Associated	Review	Time of Assessment
<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back	<input type="checkbox"/> Pain <input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Bruising <input type="checkbox"/> Other	<input type="checkbox"/> Vitals <input type="checkbox"/> ECG <input type="checkbox"/> Labs <input type="checkbox"/> Imaging <input type="checkbox"/> Other	_____ : _____ : _____ Rapid Triage RN Signature: _____

ALLERGIES - (Drug / Reactions) NONE

Medication / Drug Name	ALLERGIES	Other Information																																		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Medication</td> <td>Reaction</td> </tr> <tr> <td><input type="checkbox"/> Penicillin</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Sulfa</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Cephalosporins</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Anesthetics</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Local Anesthetics</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Contrast Media</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Blood Products</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> </tr> </table>	Medication	Reaction	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Rash	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Rash	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Rash	<input type="checkbox"/> Anesthetics	<input type="checkbox"/> Rash	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Rash	<input type="checkbox"/> Contrast Media	<input type="checkbox"/> Rash	<input type="checkbox"/> Blood Products	<input type="checkbox"/> Rash	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Food</td> <td>Reaction</td> </tr> <tr> <td><input type="checkbox"/> Shellfish</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Eggs</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Milk</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Peanuts</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Soy</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Wheat</td> <td><input type="checkbox"/> Rash</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/> Other</td> </tr> </table>	Food	Reaction	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Rash	<input type="checkbox"/> Eggs	<input type="checkbox"/> Rash	<input type="checkbox"/> Milk	<input type="checkbox"/> Rash	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Rash	<input type="checkbox"/> Soy	<input type="checkbox"/> Rash	<input type="checkbox"/> Wheat	<input type="checkbox"/> Rash	<input type="checkbox"/> Other	<input type="checkbox"/> Other	C- See Identification Medication Name I- Inpatient O- Outpatient P- Pharmacy S- Surgery U- Urgent Care W- Walk-in X- Other
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ASSESSMENT AND SIGNATURE

Assessment completed by third discipline. Time: _____