

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 resumption of admission? Yes No Is patient on probation (and employment)? Yes No

CHIEF COMPLAINT:

History <input type="checkbox"/> Present <input type="checkbox"/> Previous	ADMISSION <input type="checkbox"/> Admission <input type="checkbox"/> Transfer <input type="checkbox"/> Discharge <input type="checkbox"/> Other	RESUMPTION <input type="checkbox"/> Transfer <input type="checkbox"/> Discharge <input type="checkbox"/> Other	ADMIT <input type="checkbox"/> Trauma <input type="checkbox"/> General <input type="checkbox"/> Cardiac <input type="checkbox"/> Other	Time of Admission Hours: _____ Minutes: _____ Nurse: _____
---	---	--	--	---

Age	Sex	Race	Ethnicity	Religion	Marital Status	Occupation	Education
-----	-----	------	-----------	----------	----------------	------------	-----------

ALLERGIES - (Drug / Reactions) NONE

Smoking Status <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Former <input type="checkbox"/> Current	Medications <input type="checkbox"/> Insulin <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Heart <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Other	ALLERGIES <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Eggs <input type="checkbox"/> Shellfish <input type="checkbox"/> Latex <input type="checkbox"/> Anesthetics <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Contrast Dye <input type="checkbox"/> Other
---	---	---

PHYSICAL EXAM Vital Signs: T: _____ P: _____ R: _____ BP: _____ HEENT: _____ Chest: _____ Abdomen: _____ Extremities: _____	LABS <input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> UA <input type="checkbox"/> ECG <input type="checkbox"/> CXR <input type="checkbox"/> Other
---	--

ADMISSION <input type="checkbox"/> Admission <input type="checkbox"/> Transfer <input type="checkbox"/> Discharge <input type="checkbox"/> Other	RESUMPTION <input type="checkbox"/> Transfer <input type="checkbox"/> Discharge <input type="checkbox"/> Other	ADMIT <input type="checkbox"/> Trauma <input type="checkbox"/> General <input type="checkbox"/> Cardiac <input type="checkbox"/> Other	TIME Hours: _____ Minutes: _____ Nurse: _____
---	--	---	--

ASSESSMENT <input type="checkbox"/> Conscious <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Agitated <input type="checkbox"/> Cooperative <input type="checkbox"/> Compliant <input type="checkbox"/> Non-compliant <input type="checkbox"/> Uncooperative	PHYSICAL <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Painful <input type="checkbox"/> Swollen <input type="checkbox"/> Red <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Other	SKIN <input type="checkbox"/> Clear <input type="checkbox"/> Pale <input type="checkbox"/> Yellow <input type="checkbox"/> Cyanotic <input type="checkbox"/> Red <input type="checkbox"/> Purple <input type="checkbox"/> Bruised <input type="checkbox"/> Lacerated <input type="checkbox"/> Abraded <input type="checkbox"/> Burned <input type="checkbox"/> Faded <input type="checkbox"/> Other	SCREENING TOOL <input type="checkbox"/> Glasgow <input type="checkbox"/> AVPU <input type="checkbox"/> LOC <input type="checkbox"/> Pain <input type="checkbox"/> Temperature <input type="checkbox"/> Pulse <input type="checkbox"/> Respiration <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Oxygen Saturation <input type="checkbox"/> Other
---	---	--	--

ASSESSMENT BY SIGNATURE: _____ Date: _____

Assessment completed by third discipline. Date: _____