

TRIAGE FORM

Date _____ Patient's name _____ Time of call _____
Medic Acct # _____ Home/Work phone _____ Physician _____
Age _____ If a minor, parent's name _____
Allergies _____
Date of last OV _____ DX _____ Current medications _____
Insurance company _____
Patient complaint _____

TEMP Yes No _____ Nausea Yes No Vomiting Yes No
BLEEDING Yes No Trauma Diarrhea Yes No How long _____
OB Other Circle one Continuous Intermittent ABD Distention
Controlled Moderate
Hemorrhage LMP _____ Tetanus Immunization utd +5 +10 No
PAIN Yes No Location _____ How long _____ Radiating to _____ Constant Sharp Dull
Occurs: Ambulating Resting Eating Relieved by _____ Worsens _____
SOB Yes No Frequency _____ How Long _____ Occurs: Amb Rest Eat Worsens _____
COUGH Yes No Nonproductive Productive Color _____ Amount _____ How long _____
DRAINAGE Yes No Source _____ Color _____ Odor? Yes No
URINARY Yes No Burning Frequency Amount voided at a time Normal Small

Past medical/surgical history: _____
Level of consciousness Alert Dazed Confused Semi-conscious Coma Other _____

Nurse's notes _____

Treatment plan UC Appt. _____ Non-urgent Appt. _____ Treatment Advised
 Rx Phoned in ER visit

MD Signature _____

Nurse Signature _____