UNIVERSITY MEDICAL CENTER

EMERGENCY TRAUMA DEPARTMENT
INITIAL TRIAGE ASSESSMENT

Addressograph

Name: _____ Date ___/___/___ Arrival Time: _____ Time in Triage: _____

Age: _____ Weight: _____ Time in ETD Treatment Room: _____

ER VISIT WITHIN 72 HRS.: ❒ YES ❒ NO

PATIENT STATEMENT

_____

_____

_____

_____

_____

WORK RELATED INJURY ❒ YES ❒ NO

ARRIVED VIA: ❒ Ambulance/Mobile ICU Provider _____

❒ Wheelchair ❒ Other _____

NAME OF PRIMARY MD: _____

ADVANCE DIRECTIVE: ❒ Yes ❒ No

❒ Treat & Release ❒ Acute ❒ Trauma ❒ Prompt Care ❒ PER

Accompanied By: _____

CLASSIFICATION: ❒ Emergent ❒ Urgent ❒ Non-Urgent

AFFIX COLOR CODE HERE →

ASSESSMENT/TREATMENT

_____

_____

_____

_____

_____

_____

PSYCHOSOCIAL ASSESSMENT: _____

_____

Nutrition: _____

ALLERGIES: ❒ Denies ❒ Latex

❒ Contrast Dye ❒ Food: _____

LAST TETANUS: _____

LMP: _____

Pregnancy within last year: ❒ Yes Date_____ ❒ No

TIME	TRIAGE							
TEMP	❑O ❑R	❑O ❑R	❑O ❑R	❑O ❑R	❑O ❑R	❑O ❑R	❑O ❑R	❑O ❑R
BP								
PULSE								
RESP								
O2SAT								
PAIN INTENSITY								

Medications

Name / Purpose	*Dose/Route/Frequency*	*Name / Purpose*	*Dose/Route/Frequency*

PAST MEDICAL HISTORY: _____

_____

_____

DISCHARGE PLANNING?

NOTIFIED ❒ Yes ❒ No

Nurse's Signature: _____

Print: _____