

Your Hospital's Logo Here

# EMERGENCY DEPT RECORD

HOSPITAL #:  
EMERGENCY ROOM #:

PATIENT NAME: Last First Middle			SEX: <input type="checkbox"/> F <input type="checkbox"/> M	AGE:	ADMIN DATE:	TIME IN:
HEIGHT:	WEIGHT:	IMMUNIZATIONS CURRENT: <input type="checkbox"/> Y <input type="checkbox"/> N	ALLERGIES:			
CONDITION ON ADMISSION: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Stable <input type="checkbox"/> Critical <input type="checkbox"/> Guarded		BROUGHT IN BY: <input type="checkbox"/> Self <input type="checkbox"/> Police <input type="checkbox"/> EMS <input type="checkbox"/> Family		BROUGHT IN BY: <input type="checkbox"/> Amb <input type="checkbox"/> Stretcher <input type="checkbox"/> W/C <input type="checkbox"/> Parent's Arms		<input type="checkbox"/> Other _____
ER MD:		FAMILY MD:		LAST TETNUS:		

TIME:				CURRENT PRESCRIPTION MEDICATION	SIGNIFICANT MEDICAL HISTORY
TEMP					
PULSE					
RESP					
B / P					
PULSE OX					PREGNANT? <input type="checkbox"/> Y <input type="checkbox"/> N
GCS					EDC _____
TS					FHT _____
					LACTATING? <input type="checkbox"/> Y <input type="checkbox"/> N

USED ANY OF THE FOLLOWING IN THE PAST 72 HRS?

	Yes	No
OTC Meds	<input type="checkbox"/>	<input type="checkbox"/>
Herbs / Vitamins	<input type="checkbox"/>	<input type="checkbox"/>
Street Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes", name & amount:

NURSING ASSESSMENT & HISTORY

C/C:

PROBLEM ORIENTED PHYSICAL EXAM:

PHYSICAL FINDINGS

LAB & X-RAY

<input type="checkbox"/> CBC	<input type="checkbox"/> CXR
<input type="checkbox"/> CHEM _____	<input type="checkbox"/> URINALYSIS (Voided, CCMS, Cath)
<input type="checkbox"/> EKG	<input type="checkbox"/> OTHER:

DIAG

PHYSICIANS ORDERS and TX

I \_\_\_\_\_

O \_\_\_\_\_

Attending MD of Transfer / Admit

Instruction Sheet Given

DISPOSITION OF CASE: <input type="checkbox"/> Critical <input type="checkbox"/> Admitted: RM# _____ <input type="checkbox"/> Guarded <input type="checkbox"/> Transferred _____ FACILITY		CONDITION ON DISCHARGE: <input type="checkbox"/> Improved <input type="checkbox"/> Stable <input type="checkbox"/> Guarded <input type="checkbox"/> Good <input type="checkbox"/> Critical <input type="checkbox"/> Deceased		MODE OF DISCHARGE: <input type="checkbox"/> Ambulance <input type="checkbox"/> Ambulatory <input type="checkbox"/> W / C <input type="checkbox"/> Stretcher <input type="checkbox"/> Parents Arms <input type="checkbox"/> Other _____	
TIME OF DISCHARGE:	PHYSICIAN'S SIGNATURE	DATE:	NURSE'S SIGNATURE:	DATE:	