Your Hospital's Logo Here

EMERGENCY DEPARTMENT FAX REPORT

PATIENT IDENTIFICATION

PATIENT NAME:	AGE:	SEX:	BED:	DNR ☐ Yes ☐ No
CHIEF COMPLAINT:			ATTENDING:	
ADMITTING DIAGNOSIS:	PATHWAY: ☐ Yes ☐ No		SPEAK ENGLISH: ☐ Yes ☐ No	
ALLERGIES:	ISOLATION: ☐ Yes ☐ No (IF AFB ordered, must be in Isolation)			

TRANSCRIBED TRANSITION ORDERS: (expire 4 hours after floor arrival)

IV _____ @ _____ ml/hr. x _____ hrs. O_2 _____ **Foley:** ☐ Yes ☐ No **NG:** (to suction) ☐ Yes ☐ No

MEDS 1. _____ 3. _____

2. _____ 4. _____

Pending labs to check _____ **draw next PTT at** (for patients on Heparin) _____ ☐ AM ☐ PM

Diet: _____ ☐ REG _____ ☐ Clear Liquid _____ ☐ NPO **Activity:** ☐ Bed Rest ☐ Ad Lib

FOR FLOOR USE

TIME ORDERS NOTED:	TIME FAXED TO PHARMACY:	NURSE SIGNATURE / TITLE:

FUNCTIONAL STATUS

Mental Status:	Now:	☐ AO x 3	☐ Confused	☐ Non-verbal	☐ M.R.
	Baseline:	☐ AO x 3	☐ Confused	☐ Non-verbal	☐ M.R.
Activity:	Now:	☐ Amb. Alone	☐ w/ assistance	☐ Wheelchair	☐ Bed Bd.
	Baseline:	☐ Amb. Alone	☐ w/ assistance	☐ Wheelchair	☐ Bed Bd.

Hearing Impaired: ☐ Yes ☐ No **Vision Impaired:** ☐ Yes ☐ No

Nursing Assessment: Time _____ V.S. _____ T _____ P _____ RR _____ BP _____ (most recent)

Skin Ulcer / Wound: ☐ Yes ☐ No (if draining, do **NOT** send to 4-South / 5-South.)

I/O: _____ In _____ Out (if relevant)

MRSA: ☐ Yes (if "Yes", do NOT send to 4-South / 5-South) ☐ No

VRE: ☐ Yes (if "Yes", do NOT send to 4-South / 5-South) ☐ No

Blood Cultures Sent: ☐ Yes ☐ No **Results:** Lab _____

X-Ray _____

EKG _____

Nursing Notes: _____

MEDS & TRX given in ED.: 1. _____ 3. _____

2. _____ 4. _____

Current Emergency Department physician approved transfer to unit. ☐ Yes ☐ No

Labs reviewed by Emergency Department physician ☐ Yes ☐ No

RN SIGNATURE / TITLE:	DATE:	TIME: (Military Time)

WHITE - Original / Chart **YELLOW - Emergency Dept**

PART OF THE MEDICAL RECORD