Initial Assessment of Emergency Patients

Patient's Name_____ Age_____

Sex_____ Reg. No. _____

Body Wt. _____

Arrival Time		**Assessment Time**	
Type	□Walk in □Referred by Dr. …… to Dr. …… □Referred by Relatives/Friends …….. to Dr. …….. □Follow up case of Dr. ……..		
Previous Admission	No Yes	MLC No.	
Presenting Complaints			

Primary Assessment:

Assessment Circulation	˚□Pulse ……/min □BP……/…… m m Hg □Peripheral Pulses □Temp..... F	Assessment Airway	□Patent □Protected □Maintainable □Compromised	Assessment Breathing	RR:...../Min □Laboured □SpO_2……. % on Room Air □SpO_2……. % on O_2

Glasgow Coma Scale:						
Response	1	2	3	4	5	6
Eye Opening	None	To pressure	To speech	Spontaneous	---	---
Verbal	None	Sounds	Words	Confused	Oriented	---
Motor	None	Extension	Abnormal Flexion	Normal Flexion	Localizing	Obeying Commands

□Cardiac Monitor: □GRBS: .....mg/Dl AVPU Pupils: NSERTL/	Pain Score: □ No Pain □ Mild Pain □ Moderate Pain □ Severe Pain

Systemic Assessment:

+5

ROS	HEENT: CHEST:

	CVS: ABD: EXT: Neuro: Others:
Ample History	Allergies: Medication: Past History: Last Meal: Events Prior to the incident:
Work Diagnosis/DD	

Investigations:

POC Tests	POC Tests	Blood	Urine	X-Rays	USG	CT scan/MRI	Others

Treatment Advised:

Drug	Dose	Route	Advised By	Time
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		
		PO/IM/IV/SC		

Procedures:

Name	Done By	Notes

Referral/ Consultations:

Specialty	Physician	Opinion

Problems/ Diagnosis	
Shifted to	□ICU □HDU □Ward □Discharged to Home □Lama to:
Admitting Consultant	

Vitals	P……..., BP…… RR ……, SpO_2 ……. Temp…….
Notes:	

Vitals at the Time of Transfer	P…….	BP…… SpO_2……	RR……. Temp…….
Notes:			

Doctor's Name ……...Signature ……. Patient /

Patient Attendant Name: ……...…...Signature …….

Disclaimer

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