TM Demo Hospital # 1
123 Hospital Road
Anytown, XX, 90000
(555) 555-5555

Emergency Department - Nursing Triage Notes
Registered Date of Service: 2/4/2008 3:29:00PM

TRIAGE SCORE:
Does the patient require immediate life-saving intervention? No.
Is there acute confusion? No.
Is there a pre-existent, high risk situation? No.
Is there severe pain with objective clinical observation and a subjective pain rated as 7/10? No.
How many different resources are needed? One. Level 4.
Are there "danger zone" vital signs? No.

______________________________ [2107 TIN]

CHIEF COMPLAINT:
The patient is registered by the clerical staff complaining of "lac." [2107 TIN]

HISTORICAL DATA:
MODE OF ARRIVAL: The patient arrived by private vehicle.
HISTORIAN: The patient's history is gathered from the patient.

TRIAGE NOTE:
The patient presents with a superficial, **5** cm. laceration noted on the left forearm occurring shortly prior to arrival. The laceration is not bleeding. There is associated pain. Range of motion is normal. The distal neurovascular status is normal capillary refill, normal sensation. Denies feeling a FB sensation. There are no other injuries. The injury was sustained from a knife. [2107 TIN]

NURSING HISTORY:
The patient's tetanus immunization was <5 years. The patient is right-handed. [2107 TIN]

TRIAGE ASSESSMENT:
GENERAL: Appears alert and oriented x 3.
RESPIRATORY: There is no respiratory distress.
CARDIOVASCULAR: Rate is regular, rhythm is regular.
INTEGUMENTARY: Laceration: The skin is warm and dry. There is a superficial, **5** cm. laceration noted on the left forearm. [2107 TIN]

TRIAGE INTERVENTIONS:
DRESSINGS: A pressure dressing applied.
NURSING : ID band verified and placed on to patient. [2107 TIN]

RISK ASSESSMENT:
DOMESTIC VIOLENCE: Patient states they are free from physical harm and lives in safe environment.
FALL: No risk for falling identified during initial assessment.
LATEX SCREEN: Patient has no potential for latex allergic response.
TUBERCULOSIS: There are no symptoms identified. [2107 TIN]

PAST MEDICAL HISTORY:

JENNIE JOHNSON
555 Patient Way
Apt. #5
San Diego CA, 99999

Pt Acct #: 0000000018
Date: 2/5/2008
MRN: 00018
Age: 38Y

The patient's past medical history is unremarkable.

PAST SURGICAL HISTORY:

No history of previous surgery was obtained.

SOCIAL HISTORY:

ALCOHOL: The patient does not consume alcohol.
DRUGS: The patient denies use of illicit drugs.
TOBACCO: The patient is a non-smoker.

ALLERGIES:

None.

Electronic Signature:
TIN Nurse, Test