EMERGENCY CARE AREA SEPARATION

(Ensure all pages of the MR/265 are correctly labelled with patient's ID)

Date: ..... UR.....
Surname: .....
First Name: .....
Date of Birth: ...../...../..... Age: .....
Gender: .....

Admission:

Doctor: .....
Ward: .....
☐ Name band
Time to Ward: ..... hrs
External Services
☐ Home help
☐ District Nurse
☐ MoW
☐ HITH
☐ Other
Need to cancel: ☐ Yes ☐ No
Contact: .....

Discharge:

☐ Home
In care of: .....
Follow up: .....
Time left: ..... hrs
☐ At Own Risk
Time: .....hrs
☐ Deceased
Time: .....hrs
Referred to / for:
☐ GP ☐ Social Support
☐ OT ☐ District Nursing
☐ Physio ☐ Falls Risk
☐ Other .....

Transfer:

Time requested..... hrs
Destination .....
.....
ID Band insitu .....
Escorted by:
☐ Nurse
☐ Doctor
☐ AV
☐ MICA
☐ ARV/PIPER
☐ Other: .....
Time Left: ..... hrs

ARV/PIPER Contacted
☐ Yes ☐ No
Mode of Transport
☐ Ambulance
☐ Private Ambulance
☐ Helicopter
☐ Fixed Wing
☐ Private Car
☐ Other: .....

Transfer Documentation: ☐ With patient ☐ With escort ☐ To be faxed ☐ Patient record (copy)
☐ X-rays ☐ ECG (copy) ☐ MO/NP/RIPERN letter ☐ Ambulance record (copy) ☐ Any results

Family notified of admission / transfer: ☐ Yes Whom notified: ..... Time notified: ..... ☐ No

Valuables / clothing: ☐ With Patient ☐ With Family ☐ Stored at hospital

ISBAR Clinical handover provided by ..... Signature .....

ISBAR Clinical handover received by .....

INVESTIGATION RESULTS

Urinalysis: ..... **Time:** .....
(Please Circle)

CLEAN	SPEC	MSU	CSU	BAG
Colour			blood	
leukocytes			SG	
nitrites			ketones	
urobilinogen			bilirubin	
protein			glucose	
pH			pregancy	

Pathology or point of care:	
Troponin	
Glucose	
Potassium	
Sodium	
Haemoglobin	
White Cell Count	
Blood Alcohol	
Breathalizer	
Other	

Imaging
☐ CXR
☐ AXR
☐ Cx Spine
☐ CT
☐ Ultrasound
☐ Other

Serial ECG's Time

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION - If Applicable

I, _____ _____ give consent for_____
Given Name Surname

Health Service to forward this Generic Emergency Care Patient Record to my usual GP _____
or health professional _____
Signed _____ Date _____
Relationship to Patient _____ Signature of Witness _____

DISCHARGE AT OWN RISK

I _____ am removing _____
from the Health Services on my own responsibility and against medical advice, having had the consequences of my action and the complications of my/his/her condition fully explained to me. I absolve absolutely the hospital and its agents and employees from any further responsibilities for my/his/her treatment.
Signed _____ Date _____/_____/_____
Relationship to patient _____
Witness name _____

Health Service:

Date: ..... U.R. No: .....
Surname: ..... First Name: .....
Date of Birth: ...../...../..... Age .....
Gender .....
I Identify Myself As (Optional): .....
Address: .....
..... Post Code: .....
Telephone: ..... Usual G.P. .....
Country of Birth/State If Born In Australia: .....
Preferred Language: .....
Previous visit to E.D. ☐ Yes ☐ No Date: .....
Aboriginal or Torres Straight Islander ☐ Yes ☐ No

I IDENTITY

Support Contact: .....
Relationship: .....
Telephone: .....
Contacted? Yes ☐ No ☐ Present? Yes ☐ No ☐
Not Contacted at Patient's request ☐

Funding Category: ☐ Medicare ..... ☐ DVA ..... ☐ TAC
☐ Pensioner ..... ☐ Ambulance Member ☐ Private Fund - Name .....
☐ Work Cover - Employer .....

Pre-hospital Information: Time ..... hrs **Estimated Time of Arrival:** .....hrs Time of Accident ..... hrs
.....
.....

Mode of Accident:
☐ MVA ☐ Push Bike ☐ Pedestrian ☐ Fall ☐ Sport
☐ MBA ☐ Truck ☐ Other .....

Mode of Arrival:
☐ Ambulance Victoria ☐ Air Ambulance
☐ Private Car ☐ Other .....

S SITUATION

Airway: Compromise
☐ Obstructed
☐ Partially Obstructed
☐ Patent

Breathing: Compromise
☐ **Severe** Unable to speak, severe accessory muscle use, altered conscious state.
☐ **Moderate** Speaking in words, moderate use of accessory muscles.
☐ **Mild** Speaking in short sentences, minimal accessory muscle use.
☐ **Nil** Speaking in full sentences, no accessory muscle use.

Circulation: Compromise
☐ **Severe** Skin Pale cold moist, no peripheral pulse
☐ **Moderate** Skin Pale cool moist, no radial pulse
☐ **Mild** Skin Pale cool dry, palpable peripheral pulse.
☐ **Nil** Skin Pale/pink warm dry.
Peripheral return:
☐ <2sec ☐ >2sec

Disability:
GCS ☐ <9 ☐ 9-13 ☐ 14-15
Or
☐ Alert
☐ Verbal Response
☐ Pain Response
☐ Unresponsive
Pain score 0 - 10
.....

Other:
Last meal .....
Last drink .....
IV Access:

	1	2
Date	.....	.....
Site	.....	.....
Size	.....	.....

Triage Assessment: Time of Arrival..... Triage Category
Clinical Description: .....
.....
.....
..... Signature.....

☐ **1 -** immediate
☐ **2 -** <10 minutes
☐ **3 -** <30 minutes
☐ **4 -** <60 minutes
☐ **5 -** <120 minutes

ANY ALLERGIES & ADVERSE REACTIONS - REFER TO PAGE 6

Risk Assessment: Lives Alone ☐ Yes ☐ No Pressure Injury Risk ☐ Yes ☐ No Risk of Family Violence ☐ Yes ☐ No
Infection Provention & Control Alert Screening Completed ☐ Yes ☐ No Advance Care Directive Actively Sought ☐ Yes ☐ No
Bariatric precautions required ☐ Yes ☐ No Fall Risk ☐ Yes ☐ No Currently on Anticoagulent ☐ Yes ☐ No

Behaviour
☐ High Risk - danger to self or others and/or severe behavioural disturbance
☐ Medium Risk - possible danger to self or others and/or moderate behavioural disturbance
☐ Low Risk - no danger to self or others and/or irritable without aggression

If **Yes** box ticked refer to appropriate local risk screen tool

B BACKGROUND

Past History:
.....
.....
.....
.....
.....
.....
.....

Current Medications:
.....
.....
.....
.....
.....
.....
.....

Generic Adult Emergency Care Patient Record MR/265

Attach ADR label here or write
ALLERGIES & ADVERSE REACTIONS (ADR)
☐ **Nil known** ☐ **Unknown** (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

Sign ..... Print ..... Date .....

Date: ..... UR.....
Surname: .....
First Name: .....
Date of Birth: ...../...../..... Age: .....
Gender: .....
Height: ..... cm Weight: ..... Kg

MEDICATIONS ORDERED BY ATTENDING DOCTOR/NURSE PRACTITIONER

Date	Time	Medication (Print Generic Name)	Dose	Route	MO Signature/ Nurse Practitioner	Time Given	Given By

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1	Nurse Initials Nr 2	Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by

NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Prescriber/Nurse Initiator (NI) Print Name	Given by	Time Given	Pharmacy

MEDICATIONS SUPPLIED BY NURSE WITH SCHEDULED MEDICINES (RURAL AND ISOLATED PRACTICE) ENDORSEMENT

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Duration	Health Management Protocol	Administered / Supplied by

STANDING ORDERS

Date Time	Medication (Print Generic Name)	Route	Dose	Standing Order No.	Standing Order Condition	Nurse Initiator	Given By	Time Given

IV ORDERS

Date	Type of Fluid Including Strength	Amount	Additions to Flask/Blood Pack No.	Rate	MO Signature	Signature of Person Administering	Signature of Person Checking	Admin Time Start	Admin Time End

FLUID BALANCE WORKSHEET

	Intake (Recorded in mls)					Output (Recorded in mls)		
Time	Oral	IV Line (1)	Through Volume	IV Line (2)	Through Volume	Urine	Vomit	Other (Bowels)

Progress Notes:
Documentation of care, treatment and response to treatment should occur at the time of the intervention.

Date: .... UR...
Surname: ....
First Name: ....
Date of Birth: .... /........... /........... Age: ....
Gender: ....

Time	

Artwork
December 2019
Fletcher Printers
To Re-Order
PH. (03) 5335 5688
Email
info@fletcherprint.com.au

A
ASSESSMENT

Observations to be undertaken on arrival and at least every 30 minutes until stable or as determined by clinical need

Date: .... UR...
Surname: ....
First Name: ....
Date of Birth: .... /........... /........... Age: ....
Gender: ....

Date	Time															
Respiratory Rate (breaths / min)	Write ≥ 30															
	25-29															
	20-24															
	15-19															
	10-14															
	5-9															
	Write ≤ 4															
O_2 Saturation (%)	Write ≥ 96															
	90-95															
	87-89															
	Write ≤ 86															
O_2 Flow Rate (L/Min)	Write ≥ 13															
	Write ≤ 3-12															
Room Air	R/A															
If systolic BP ≥ 200, write value in box	Write 200s															
	190s															
	180s															
	170s															
Blood Pressure (mmHg)	160s															
	150s															
	140s															
	130s															
	120s															
	110s															
	100s															
	90s															
If diastolic BP ≤ 50, write value in box	80s															
	70s															
	Write ≤ 60															
	Write ≤ 50															
If heart rate ≥ 150, write value in box	Write ≥140															
	130s															
	120s															
	110s															
	100s															
Heart Rate (beats / min)	90s															
	80s															
	70s															
	60s															
If heart rate ≤ 30, write value in box	50s															
	Write 40s															
	Write 30s															
Heart Rhythm	Write															
Temperature (C)	Write ≥ 38.6															
	37.6-38.5															
	36.6-37.5															
	35.5-36.5															
	Write ≤ 35.4															
Neurological Assessment: Right Pupil	Size															
	Reac															
Left Pupil	Size															
	Reac															
Arm Strength	L															
	R															
Leg Strength	L															
	R															
GCS: Best Motor Response																
Best Verbal Response																
Best Eye Opening																
Score																
Pain Score None (0) - Worst (10)	Write															
Blood Glucose Level	Write															
Intervention	Reference Letter															
Initials																

R
REQUEST

Sign all entries with name and designation

Date: .... UR...
Surname: ....
First Name: ....
Date of Birth: .... /........... /........... Age: ....
Gender: ....

Medical Officer/Nurse Practitioner Management Plan (If applicable)

Name .... Time Notified .... hrs

Coming To See Patient ☐ Yes ☐ No ETA ....hrs Time Seen ....hrs

Advice Given: ....
....
....
....
....

Signature ....

Deteriorating patient review criteria - Use clinical judgement

These instructions explain **when** to make a clinical review or rapid response call.
Your local policies will explain **how** to make the call

Clinical review criteria	Rapid response criteria
• Any observation in the orange area. • New or unrelenting chest pain. • Unrelenting or unexpected pain. • New or unrelenting shortness of breath • Increased or unexpected fluid or blood loss. • Decrease in level of consciousness or GCS 13 or less. • You are worried about the patient but they do not fit the above criteria.	• Any observation in the purple area. • Airway threat. • Respiratory threat. • Marked decrease in 02 saturation to below 90%. • Seizure activity. • Marked decrease in GCS or GCS less than 10. • You are worried about the patient but they do not fit the above criteria.

General instructions

- Ensure a full set of vital signs if patient is deteriorating or an observation is in any of the coloured areas.
- Considerations
  - Whether the abnormal observation(s) reflect(s) deterioration in the patient.
  - Look for trends in patients condition.
  - What is usual for the patient.
- Document actions taken in progress notes including time and results of any interventions.
- When graphing observations, place a dot (•) in the centre of the box which includes the current observation in its range of values and connect it to the previous dot with a straight line. For blood pressure, use the symbol indicated on the chart.
- Whenever an observation falls within the shaded area, you must initiate the actions required for that colour, unless a modification has been made.
- If observations fall within both purple and orange coloured areas for the same time period, the actions required for the purple area apply.

Consider any advanced care directives or consultation with family if patient unknown

INTERVENTIONS ASSOCIATED WITH ABNORMAL VITAL SIGNS

If you administer an intervention, record here and note letter in intervention row over page in appropriate time column

Reference Letter	Intervention (initial if required)
a	
b	
c	
d	
e	
f	
g	

NEUROLOGICAL ASSESSMENT

Glasgow Coma Score

Best Motor Response	Best Verbal Response	Best Eye Opening
6. Obeying	5. Oriented	4. Spontaneous
5. Localising	4. Confused	3. To voice
4. Withdrawal	3. Inappropriate	2. To pain
3. Flexing	2.Incomprehensible	1. None
2. Extending	1. None	
1. None		

GCS Total = 3 to 15

Motor Strength Limbs
5. Normal power
4. Mild weakness
3. Moderate weakness
2. Severe weakness
1. No response

Pupil Size mm