TRIAGE ASSESSMENT FORM

Facility Name: _____

Patient Name: _____

Date of Birth: _____

Gender: _____ Triage Nurse: _____

Vital Signs:

Temperature (°F): _____ Pulse (bpm): _____

Respiratory Rate (breaths/min): _____ Blood Pressure (mmHg): _____

Oxygen Saturation (%): _____

Chief Complaint:

Describe the primary reason for the patient's visit or presenting problem, including onset, duration, and severity.

History of Present Illness:

Provide a detailed narrative of symptoms, associated factors, prior treatments, and any pertinent negatives.

Past Medical History:

List relevant past medical conditions, surgeries, hospitalizations, allergies, and medications.

Social History:

Include lifestyle factors such as tobacco, alcohol, drug use, living situation, and occupational exposures.

Family History:

Document familial diseases and conditions relevant to the patient's current presentation.

Review of Systems:

Summarize pertinent positives and negatives across major organ systems.

Physical Examination Findings:

Record vital examination findings and any abnormalities detected.

Triage Category / Priority Level: _____

Initial Nursing Assessment Comments:

Provide observations, concerns, or additional notes relevant to patient triage and care prioritization.

Nurse Signature: _____

Physician/Provider Review and Comments:

Document physician or provider's review notes, recommendations, or orders post-triage.

Physician/Provider Signature: _____

Legal Notice:

This Triage Assessment Form is intended to document the initial evaluation of the patient and to assist in prioritizing care based on presenting conditions. It does not substitute for a complete medical evaluation or diagnosis. All information provided herein is confidential and protected under applicable U.S. laws including HIPAA. Unauthorized disclosure is prohibited. Completion of this form implies consent for evaluation and treatment as appropriate. This document shall be governed by and construed in accordance with the laws of the United States of America.

NURSE SIGNATURE **PHYSICIAN/PROVIDER SIGNATURE**

Date: _____ Date: _____