TRIAGE AND EMERGENCY DEPARTMENT RECORD
Guidelines for Completion

Data Required	Completion Instructions	Source
Addressograph information	Patient demographics, entered on right upper corner of each page.	Patient ID card - HIS
Date	Enter the date of triage.	Nurse
"Critical First Look Scan"	Take a quick look at the patient upon entering the ED. For adults, scan airway, breathing, circulation, and disability. For pediatrics, scan general appearance, work of breathing, and circulation. Address critical presenting status STAT. Documentation is captured for each patient in the description of how they presented to the ED, under objective assessment. For example: patient arrived ambulating without assistance and in no apparent distress; or – patient arrived ambulating, supported by spouse, clutching chest, pale and diaphoretic, …	Nurse
Time of Triage	Enter the time that the patient is triaged by the nurse.	Nurse
Language(s)	Enter the language(s) spoken and understood by the patient and/or designate.	Patient or Designate
Subjective	Identify reason for ED visit and its history. This may differ from the presenting complaint.	Patient or Designate
Objective	Enter observable signs.	Nurse
Medical/Surgical History:	Summarize the patient's past medical and surgical history.	Patient or Designate
Fall in the last year:	Select "Yes" or "No". If yes, indicate if falls risk alert identifier has been applied. This status can be modified during the secondary assessment.	Patient or Designate
Allergies:	Indicate if the patient has allergies. If yes, list the allergen(s) and the reaction. Apply alert identifier (select "yes" or "no").	Patient or Designate
Immunizations:	Select the most appropriate box for the immunization status.	Patient or Designate
Medications	Complete the table and/or attach a supplementary list of prescribed and over-the-counter medications. Complete a medication reconciliation if the patient is admitted.	Multiple sources
Mechanism of Injury	If the patient is injured, indicate the mechanism of injury (MOI) – that is, the nature and extent of the trauma. Some examples of high risk of injury include: ejection / rollover / extrication from vehicles; motorcycle collision with a car at speed of >30 km/hr.; pedestrian struck by a vehicle; fall from >3ft or > 1m or 5 steps. CTAS score for presence of a high MOI is at least a level 2. Select the box for "yes" or for "no" based on above criteria.	EMS; Patient
EMS Treatment …	Identify key interventions provided by EMS on route.	EMS
Airway	Select applicable box(es). If the airway is obstructed or patient is experiencing stridor, provide immediate interventions.	Nurse
Breathing	Select all applicable boxes.	Nurse
Hemodynamic Stability	Select all applicable boxes. If applicable, proceed to standardized care maps. If yes, indicate which care map.	Nurse
Level of Consciousness	Select all applicable boxes. If the patient's condition is not stable, supplement the assessment by using the "neurological record"; indicate if used.	Nurse
Vital Signs and Blood Glucose	Record vital signs, etc. in allocated areas.	Nurse
Pain Scale	Assessment of pain is captured using the pain scale – circle the number that the patient identifies.	Patient
Infection Control	Determine if isolation is required based on screening criteria. Indicate if isolation is implemented.	Patient; chart
CTAS Level / Priority	Assign the most appropriate CTAS acuity level based on all data.	Nurse

Data Required	Completion Instructions	Source
Presenting Complaint (CEDIS)	Select one from the CEDIS list by objectively identifying only one from multiple complaints that results in highest CTAS level.	CEDIS list
Triage Treatment	Indicate any treatment provided in the triage area.	Nurse
Disposition	Select all applicable boxes.	Nurse
Triage Nurse Signature	The nurse completing the assessment dates, signs, and includes their professional designation on the line provided.	Nurse
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Triage Reassessment	Triaged patients directed to waiting room are to be reassessed at specific intervals based on their level of acuity, as per CTAS guidelines. Initial each entry.	Nurse
Date and Time to treatment area	Enter the time at which the patient is moved from triage area to any of the treatment areas. If the patient is triaged in a treatment room by the same nurse, select N/A	Nurse
FOCUSED SECONDARY ASSESSMENT (NB: For non-regional sites, if an admission of the patient is anticipated, an inpatient Nursing Admission History can replace this focused assessment.)		
Vital signs	A secondary assessment begins with a new set of vital signs.	Nurse
Systems' Assessments	Systems identified that are shaded must be assessed for all patients. Entrance/presenting complaint(s) will inform the need for assessment of other systems. All documentation must reflect the nursing process. If the area provided for documentation is insufficient, continue down the page and/or on the vital signs and progress notes section.	Nurse
Signature of the Nurse	The nurse completing the assessment dates, signs, and includes their professional designation on the line provided.	Nurse
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Vital Signs and Progress Notes	Document all assessments/reassessment in this section. If the area is insufficient to capture all of the assessments, proceed to a separate Vital Signs and Progress Notes form. Initial each entry.	Nurse(s)
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Health Care Directive	Indicate if patient has a health care directive by selecting the box for "yes" or for "no".	Patient or Designate
ACP status	Indicate goals of care by selecting the box for "R" (resuscitation), "M" (medical care only), "C" (comfort care only), or for "NA" if it has not been determined. ACP-R is the default goal of care.	Patient or Designate or Chart
Schmidt Falls Risk Screening and Required Measures	Complete to assess risk for falls if indicated. If the patient's score is less than 3, the patient is at low risk for falls and apply regular precautions. If the risk score is 3 or greater, initial each intervention that is implemented. Reassess risks as per falls prevention policy.	Nurse
Date, Time, and Signature	Enter date, time, and signature for completed falls risk assessment.	Nurse
If Admitted or If Discharged or if Reassessed	Indicate if high risk for falls is communicated to receiving unit or addressed with patient on discharge. Complete a falls risk reassessment if indicated. Document date, time, reason and score of the reassessment. Enter signature and professional designation.	Nurse
Discharge Instructions Provided	If the patient is discharged home, indicate if discharge instructions were provided.	Nurse
Guide to CTAS acuity levels & Second Order Modifiers	Guides to CTAS acuity levels for 1st order modifiers and condition that supplement these 1st order modifiers to identify the patient's level of acuity.	N/A