Outpatient Nursing Assessment and Triage Form

Clinical Documentation - For Print and Patient Record

1. PATIENT DEMOGRAPHICS			
Patient Full Name:		**Date of Birth (MM/DD/YYYY):**	
Medical Record Number (MRN):		**Gender / Pronouns:**	
Date of Assessment:		**Arrival Time:**	
Accompanied By:		**Mode of Arrival:**	

2. TRIAGE & CHIEF COMPLAINT	
Chief Complaint (Patient's own words):	
History of Present Illness / Symptoms:	
Triage Acuity Level (1-5 / Emergency to Non-Urgent):	e.g., Level 3 - Urgent
Allocated Care Area / Room:	

3. VITAL SIGNS					
Blood Pressure:	mmHg	**Heart Rate:**	bpm	**Respiratory Rate:**	/min
Temperature:	Â°F or Â°C	**SpO2:**	% on Room Air/O	**Weight:**	kg or lbs
Pain Score (0 - 10):	Score	**Pain Location:**		**Pain Character:**	Sharp, dull, throbb

4. ALLERGIES & CURRENT MEDICATIONS	
Allergies (Medication, Food, Latex, Environmental):	List details and reactions
Current Medications:	Name, dosage, frequency
Last Oral Intake (Time/Item):	

5. INITIAL NURSING ASSESSMENT	
Neurological / Mental Status:	Alert, oriented x3, lethargic, confused, etc.
Cardiovascular:	Regular rhythm, pulses present, edema, etc.
Respiratory Effort & Lung Sounds:	Clear, wheezing, crackles, unlabored, etc.
Gastrointestinal / Genitourinary:	Abdomen soft, bowel sounds present, last BM, dysuria, etc.
Integumentary / Skin:	Warm, dry, intact, lesions, rashes, wounds, etc.
Musculoskeletal / Mobility:	Steady gait, assistive devices, range of motion, etc.

6. SAFETY & CLINICAL SCREENINGS

Fall Risk Assessment:	Low / Medium / High Risk	**Infectious Disease Screen:**	Travel history, fever, cough?
Domestic Violence / Safety Screen:	Feels safe at home?	**Substance / Alcohol Screen:**	

7. TRIAGE DISPOSITION & INTERVENTIONS	
Immediate Interventions Performed:	O2 started, ice pack, wound cleaned, etc.
Disposition Recommendation:	Wait in lobby, immediate bed placement, transfer to ED, etc.
Additional Nursing Notes:	

8. SIGN-OFF & AUTHORIZATION			
Assessing Nurse Signature:		**Credentials:**	RN / LPN
Date signed:		**Time signed:**	