

Date: _____

Location in Department

Patient label

Name/pronoun used:

Primary Assessment	Time: _____ Initial: _____	Name/pronoun used:
AIRWAY	Airway Interventions <input type="checkbox"/> None	
<input type="checkbox"/> Clear <input type="checkbox"/> Maintains own <input type="checkbox"/> Unable to maintain	<input type="checkbox"/> Positioning <input type="checkbox"/> Suctioning <input type="checkbox"/> Foreign body removed <input type="checkbox"/> C-Spine precautions <input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway <input type="checkbox"/> Advanced Airway Size _____	
Comments:		
BREATHING	CIRCULATION	
Work of Breathing: <input type="checkbox"/> Respirations even/Unlaboured <input type="checkbox"/> Nasal flaring <input type="checkbox"/> Tracheal tug <input type="checkbox"/> Head bobbing <input type="checkbox"/> Tripod <input type="checkbox"/> Indrawing: _____ <input type="checkbox"/> Abdominal breathing <input type="checkbox"/> Chest Symmetrical <input type="checkbox"/> Chest Nonsymmetrical	Adventitious Sounds: <input type="checkbox"/> Snoring <input type="checkbox"/> Stridor <input type="checkbox"/> Wheezing <input type="checkbox"/> Gurgling <input type="checkbox"/> Grunting <input type="checkbox"/> Crackles	Pulses Central: <input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Bounding <input type="checkbox"/> Absent <input type="checkbox"/> Doppler
Air Entry: A - Absent N - Normal ↓ - Decreased W - Wheezes C - Crackles	Cough: <input type="checkbox"/> None <input type="checkbox"/> Productive <input type="checkbox"/> Non-productive	Skin Temperature: <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Dry <input type="checkbox"/> Diaphoretic
	Fontanelles: <input type="checkbox"/> Closed <input type="checkbox"/> Soft/Flat <input type="checkbox"/> Depressed <input type="checkbox"/> Bulging	Colour: <input type="checkbox"/> Normal <input type="checkbox"/> Pale <input type="checkbox"/> Flushed <input type="checkbox"/> Cyanotic <input type="checkbox"/> Mottled <input type="checkbox"/> Jaundice
Comments:	Comments:	
Breathing Interventions <input type="checkbox"/> None	Circulation Interventions <input type="checkbox"/> None	
<input type="checkbox"/> SpO ₂ Monitoring <input type="checkbox"/> ABG <input type="checkbox"/> RT called <input type="checkbox"/> Capnography <input type="checkbox"/> Oxygen by: <input type="checkbox"/> Nasal Prongs <input type="checkbox"/> Face mask <input type="checkbox"/> Non-rebreather _____ Lpm <input type="checkbox"/> Heated Humidified High Flow Therapy _____ FIO ₂ <input type="checkbox"/> BVM at 100% <input type="checkbox"/> PRAM initiated <input type="checkbox"/> Needle Thoracostomy <input type="checkbox"/> L <input type="checkbox"/> R Time: _____ <input type="checkbox"/> Chest tube <input type="checkbox"/> L <input type="checkbox"/> R Time: _____ Size: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cardiorespiratory Monitoring <input type="checkbox"/> Vascular access obtained (see fluid balance record) <input type="checkbox"/> Fluid bolus initiated (see fluid balance record) <input type="checkbox"/> CPR initiated (see resuscitation record) <input type="checkbox"/> Other: _____	
DISABILITY/NEUROLOGICAL STATUS	Disability Interventions <input type="checkbox"/> None	
<input type="checkbox"/> Glucose POCT: _____ <input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive <input type="checkbox"/> Behavior normal for child <input type="checkbox"/> Seizure activity <input type="checkbox"/> Extremity weakness/deficits <input type="checkbox"/> Hypotonia/Floppy <input type="checkbox"/> Headache <input type="checkbox"/> Photophobia <input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Siderails up <input type="checkbox"/> Seizure pads on siderails <input type="checkbox"/> Universal falls precautions initiated	
Pupils: <input type="checkbox"/> PERRLA Right: _____ mm Left: _____ mm <input type="checkbox"/> Brisk <input type="checkbox"/> Sluggish <input type="checkbox"/> Fixed	Pupil size (mm) 	
Comments:		
EXPOSURE	Exposure Interventions <input type="checkbox"/> None	
<input type="checkbox"/> Clothing removed	<input type="checkbox"/> Active re-warming: _____	

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Secondary Assessment	Time: _____ Initial: _____	Name/pronoun used:					
MUSCULOSKELETAL	Musculoskeletal Interventions <input type="checkbox"/> None						
	<input type="checkbox"/> Dressings applied <input type="checkbox"/> Splint: _____						
	# Fracture D Deformity POI Pattern of injury #C Compound E Edema Fracture Er Erythema Pu Purpura A Abrasion H Hematoma R Rash AM Amputation L Laceration S Swelling B Burn P Pain T Traction Bi Bite Pet Petechiae /// Crush BI Bleeding PI Penetrating + Bruising C Contusion Injury						
<input type="checkbox"/> Concerns for non-accidental trauma (refer to guide for use); MRP made aware <input type="checkbox"/> As per Duty to Report Legislation call made to MCFD 1-800-663-9122							
Comments:							
CARDIOVASCULAR	Cardiovascular Interventions <input type="checkbox"/> None						
Heart Sounds: <input type="checkbox"/> S1, S2 clear Heart Rhythm: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Chest Pain: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes Description: _____	<input type="checkbox"/> Cardiorespiratory Monitoring <input type="checkbox"/> ECG (e.g. 12 lead) Time: _____					
Lead: _____ Impression: _____ Rate: _____ PR: _____ QRS: _____ QT: _____							
ABBREVIATIONS							
ABG	Arterial Blood Gas	FI ₀₂	Fraction of Inspired Oxygen	mm	Millimetre	PEWS	Pediatric Early Warning System
ADR	Adverse Drug Reaction	h	Hour	mmol/L	Millimole per litre	POCT	Point Of Care Testing
BP	Blood Pressure	HR	Heart Rate	MRP	Most Responsible Practitioner	PRAM	Pediatric Respiratory Assessment Measure
BVM	Bag Valve Mask	IDC	Independent Double Check	#	Number	PTN	Patient Transfer Network
CEDIS	Canadian Emergency Department Information System	kg	Kilogram	N/A	Not Applicable	R	Right
cm	Centimeter	L	Left	NG	Nasogastric	Resp	Respiration
CPR	Cardiopulmonary Resuscitation	LBM	Last Bowel Movement	NKDA	No Known Drug Allergies	RN	Registered Nurse
C-Spine	Cervical Spine	LMP	Last Menstrual Period	NPO	Nothing Per Mouth	RT	Respiratory Therapist
CTAS	Canadian Triage and Acuity Scale	Lpm	Litre per minute	O ₂ Sat	Oxygen Saturation	S1S2	First heart sound, Second heart sound
ECG	Electrocardiogram	MCFD	Ministry of Children and Family Development	OG	Orogastric	SpO ₂	Saturation of Peripheral Oxygen
ED	Emergency Department	mL	Milliliter	PERRLA	Pupils Equal, Round and React to Light and Accommodation	Temp	Temperature

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GASTROINTESTINAL	Gastrointestinal Interventions <input type="checkbox"/> None	
Bowel Sounds: <input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> NG tube <input type="checkbox"/> OG tube Size: _____ <input type="checkbox"/> L <input type="checkbox"/> R Length: _____ Time: _____	
Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Rigid <input type="checkbox"/> Non-tender on palpation <input type="checkbox"/> Tender/Pain: _____ <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Tubes insitu: _____ <input type="checkbox"/> Breast fed <input type="checkbox"/> Formula	Symptoms: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting # of times _____ colour _____ <input type="checkbox"/> Hematemesis <input type="checkbox"/> Diarrhea # of times _____ colour _____ <input type="checkbox"/> Constipation <input type="checkbox"/> LBM: _____	
Comments:		
GENITOURINARY	Genitourinary Interventions <input type="checkbox"/> None	
<input type="checkbox"/> Pain: _____ <input type="checkbox"/> Burning <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Hematuria <input type="checkbox"/> Last void: _____ <input type="checkbox"/> Number of wet diapers in last 24 hours: _____	Penile/Scrotal: <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Swelling Vaginal: <input type="checkbox"/> Bleeding <input type="checkbox"/> Pain <input type="checkbox"/> Discharge	Catheter type: <input type="checkbox"/> Foley <input type="checkbox"/> Other: _____ Size: _____ Time: _____ <input type="checkbox"/> Urine POCT <input type="checkbox"/> Mid-stream <input type="checkbox"/> Catheter <input type="checkbox"/> Negative <input type="checkbox"/> Positive: _____
Comments:		
REPRODUCTION <input type="checkbox"/> N/A	Reproduction Interventions <input type="checkbox"/> None	
<input type="checkbox"/> LMP: _____ <input type="checkbox"/> Sexually active <input type="checkbox"/> Pregnant: _____ weeks Gravida: _____ Para: _____ Abortus: _____ <input type="checkbox"/> Discharge <input type="checkbox"/> Bleeding Amount: _____ Duration: _____	<input type="checkbox"/> Pregnancy test: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	
Comments:		
MENTAL HEALTH & SUBSTANCE USE	Interventions <input type="checkbox"/> None	
<input type="checkbox"/> Section 28 with police <input type="checkbox"/> Form 21 Status: <input type="checkbox"/> Appropriate <input type="checkbox"/> Confused/Disoriented <input type="checkbox"/> Angry/Irritable <input type="checkbox"/> Paranoid/Suspicious <input type="checkbox"/> Agitated/Impulsive <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Certified/Admitted involuntarily via the Mental Health Act Contact: <input type="checkbox"/> Patient aware <input type="checkbox"/> Indigenous Patient Liaison <input type="checkbox"/> Social Worker <input type="checkbox"/> Mental Health Team <input type="checkbox"/> Substance Use Team <input type="checkbox"/> Concurrent Disorders Team <input type="checkbox"/> Other: _____ <input type="checkbox"/> Validated screening tool(s) used based on risks identified: _____ <input type="checkbox"/> Violence and Aggression ALERT completed <input type="checkbox"/> Safety/Risk Mitigation Plan initiated	
Nicotine Use: <input type="checkbox"/> N/A Alcohol Use: <input type="checkbox"/> N/A Substance Use: <input type="checkbox"/> N/A Type: _____ Type: _____ Type: _____ Route: _____ How much: _____ Route: _____ How much: _____ How often: _____ How much: _____ How often: _____ Last time used: _____ How often: _____ Last time used: _____ Last time used: _____	Risks Identified: <input type="checkbox"/> None <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Homicidal ideation <input type="checkbox"/> Flight risk <input type="checkbox"/> Self harm <input type="checkbox"/> Self-deterioration <input type="checkbox"/> Substance Withdrawal	
<input type="checkbox"/> Stated plan for harm: _____		
Comments:		