


ACS PATIENT RECORD

Demographic	Patient Name: _____ DOB/Age: _____ Parent / Guardian: _____ Primary Physician: _____ DIN: _____ MRN: _____ Allergies: _____ <input type="checkbox"/> NKA																																																	
History	Chief Complaint: _____ Significant Medical History: _____ Last Menstrual Period: _____ Pregnancy Status: _____ <table style="width:100%;"> <tr> <td style="width:30%;">Glasgow Coma Scale</td> <td>Field Triage Category: _____ Site Triage Category: _____</td> </tr> <tr> <td>Eye</td> <td>Pupil Size L: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Motor</td> <td>Pupil Size R: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Verbal</td> <td>Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)</td> </tr> <tr> <td>Total</td> <td>Circle pain¹ (Child/Other)</td> </tr> </table> <div style="display: flex; justify-content: center; align-items: center; gap: 10px;">  </div> <table style="width:100%; margin-top: 10px;"> <tr> <td style="width:50%;">Time recorded: _____</td> <td style="width:25%;">Intake</td> <td style="width:25%;">Output</td> </tr> <tr> <td>Temp: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pulse: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Respiration: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Blood Pressure: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Notes: _____</td> <td>Total</td> <td>Total</td> </tr> </table> Special Dietary Needs: _____ <table border="1" style="width:100%; margin-top: 10px;"> <thead> <tr> <th colspan="4" style="text-align:center;">Medications</th> </tr> <tr> <th style="width:60%;">Name</th> <th style="width:10%;">Route</th> <th style="width:10%;">Dose</th> <th style="width:20%;">Time Frequency</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> Physician initials: _____ Nurse initials: _____ Other initials: _____		Glasgow Coma Scale	Field Triage Category: _____ Site Triage Category: _____	Eye	Pupil Size L: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No	Motor	Pupil Size R: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal	Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)	Total	Circle pain ¹ (Child/Other)	Time recorded: _____	Intake	Output	Temp: _____	_____	_____	Pulse: _____	_____	_____	Respiration: _____	_____	_____	Blood Pressure: _____	_____	_____	Notes: _____	Total	Total	Medications				Name	Route	Dose	Time Frequency												
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Physical Exam	Cardiovascular: _____ Pulmonary: _____ Neurological: _____ Other Significant Findings: _____ Physician initials: _____																																																	
Re-Assessment	Date: _____ Time: _____ System Review: Temp: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____ Lab Results: _____ X-ray Results: _____ Physician initials: _____ Nurse initials: _____ Other initials: _____																																																	
Procedure / Disposition	Pre-Procedure DX: _____ Post-Procedure DX: _____ Procedure: _____ Findings: _____ Condition of Patient Post Procedure: <input type="checkbox"/> Critical <input type="checkbox"/> Guarded <input type="checkbox"/> Stable Discharge Instructions (YES/NO): Written _____ Verbal _____ Diet: <input type="checkbox"/> Regular <input type="checkbox"/> Soft <input type="checkbox"/> Liquid <input type="checkbox"/> Other: _____ Activities: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Restrictions as Follows: _____ Discharge Medications: _____ Follow-Up Visit: When _____ NA: _____ Condition at discharge: ___ Critical ___ Guarded ___ Stable ___ Fair ___ Deceased ___ Temp ___ Pulse ___ Respiration ___ Blood Pressure Discharge: <input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> ACS <input type="checkbox"/> SNF <input type="checkbox"/> Deceased Date: _____ <input type="checkbox"/> Transfer: _____ <input type="checkbox"/> Other: _____ Time: _____ Admitted: <input type="checkbox"/> Time admitted: _____ Physician order: _____ Notes: _____ Physician initials: _____ Nurse initials: _____ Other initials: _____																																																	