MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Emergency Department
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

Emergency Nursing Care Record

Form MS 560 **TRIAL** (Rev 10.2010)

Affix Patient Label

Time (HH:MM)	Progress Notes

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Emergency Department
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

Emergency Nursing Care Record

Form MS 560 **TRIAL** (Rev 10.2010)

Affix Patient Label

Date ____________ (YYYY MM DD) Time ____________ (HH.MM)

Room ____________

Presenting Health Problem

Health History/Allergies

Smoker ☐ Yes ☐ No

☐ Brought in by police: Badge #

☐ Security arrived to bedside: Time ________ (HH.MM)

- **Airway**
  ☐ Patent ☐ Compromised
- **Breathing**
  ☐ No respiratory distress ☐ Mild distress
  ☐ Moderate distress ☐ Severe distress
- **Breath Sounds**
  ☐ Equal, clear bilaterally ☐ Crackles ☐ Wheezes
  ☐ Other ____________
- **Circulation**
  Skin colour________ Skin temperature________ Diaphoresis________
- **Radial Pulse**
  ☐ Strong ☐ Regular ☐ Weak ☐ Irregular
- **Hydration**
  ☐ Well hydrated ☐ Mild dehydration
  ☐ Moderate dehydration ☐ Severe dehydration
- **Neurologic** ☐ Awake, alert and oriented
  ☐ Altered LOC *(See Neuro Vital Sign Record, page 3)*
- **Abdomen** ☐ N/A
  Bowel Sounds ________ Distention ________
  Guarding ________ Rigidity ________
- **Genito-Urinary** ☐ N/A
  Dysuria ________ Hematuria ________
  Frequency ________ Flank pain ☐ Right ☐ Left
- **Gynecologic** ☐ N/A
  Last menstrual period ________ (YYYY MM DD) Gravida/Para ________
  Vaginal bleeding Amount ________ Duration ________

- **Pain** ☐ N/A
  Location ________ Radiation ________
  Quality ________ Time of onset ________ (HH.MM)
  Provoked by/Alleviated by ________
  Pain Score ________ **/10**
- **Symptoms** ☐ N/A
  Nausea ________ Vomiting ________
  Diarrhea ________ Last bowel movemt ________ (YYYY MM DD HH:MM)
- **Social Situation** Language Spoken ________
  ☐ Interpretation Services contacted
  ☐ Lives with family/friend ☐ Lives alone ☐ Has CCAC
  ☐ Other ________
  Clothing/Belongings/ Own Medications given to:
  ☐ With patient ☐ Family ☐ Security ☐ Other ________
- **ISAR (For all Patients >65)** ☐ N/A

1) Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?	☐ Yes 01 ☐ No 00
2) In the last 24 hours, have you needed more help than usual?	☐ Yes 01 ☐ No 00
3) Have you been hospitalized for one or more nights during the past six months?	☐ Yes 01 ☐ No 00
4) In general, do you have problems with your vision?	☐ Yes 01 ☐ No 00
5) In general, do you have serious problems with your memory?	☐ Yes 01 ☐ No 00
6) Do you take six or more medications every day?	☐ Yes 01 ☐ No 00
Positive test is 2 or more	Total /6

Initial Assessment by ____________ , RN
Signature of Nurse

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Emergency Department
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

Emergency Nursing Care Record

Form MS 560 **TRIAL** (Rev 10.2010)

Affix Patient Label

Interventions

Time (HH:MM)	Intravenous Initiation	Gauge	Intravenous Location	Initials
	Site #1			
	Site #2			
	Site #3			
	Site #4			

Time (HH:MM)	Interventions	Size	Site / Comments / Drainage	Initials
	Urinary Catheter			
	Gastric Tube			
	Central Line			
	Arterial Line			

CBGM

Time (HH:MM)	Value	Initial

Intravenous Intake

Time (HH:MM)	Site #	Bag #	Solution	Volume	Rate	End Time (HH:MM)	Initials

Time (HH:MM)	Intake	Output	Initials

Medications

Time (HH:MM)	Medication	Dose	Route	Initials	Time (HH:MM)	Effect	Initials

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Emergency Department
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

Emergency Nursing Care Record

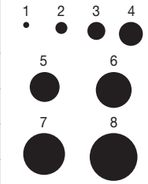
Form MS 560 **TRIAL** (Rev 10.2010)

Affix Patient Label

Vital Signs

Time (HH:MM)	Heart Rate	Cardiac Rhythm	Blood Pressure	Respiratory Rate	SpO_2	Oxygen LPM %	Temperature	Pain	Eyes	Verbal	Motor	Glasgow Coma Scale	+ / - CAM	Pupils L Size mm	Pupils L React + / -	Pupils R Size mm	Pupils R React + / -	Strength Arm R	Strength Arm L	Strength Leg R	Strength Leg L	Initials

Pupils (size in mm)



Eyes
4 = Spontaneous
3 = To voice
2 = To pain
1 = None
S = Swollen shut

Verbal
5 = Oriented
4 = Disoriented
3 = Inappropriate words
2 = Incomprehensible sounds
1 = None
T = ET Tube/Trach

Motor
6 = Obeys commands
5 = Localizes pain
4 = Withdraw pain
3 = Flex to pain
2 = Extend to pain
1 = None

Strength
N = Normal
W = Weak
A = Absent

Transfer Summary

Date (YYYY.MM.DD)	Time (HH.MM)	Unit	Report given by	Report given to

Discharge Summary

Date (YYYY.MM.DD)	Time (HH.MM)	Accompanied by	Method of transportation

Follow-up Plan

Written Instructions

Health Teaching

Discharge Nurse

PRINT Name	Initials	PRINT Name	Initials