CEDAR CREEK HOSPITAL of Michigan

Patient Label

Triage Form

Patient Name: _____ Date of Birth: _____ Age: _____

Name of Person Completing Form: _____

Relationship: _____

What level of service are you seeking today? (Check all that Apply)

____Inpatient Treatment ____ Outpatient Treatment ____Unsure, Prefer a Recommendation

Do you have any allergies to medication or food:_____

Medical Status	Yes	No	Medical Status	Yes	No
Urinary Tract Infection			Hypertension		
Asthma/COPD/ Shortness of breath			Incontinence		
Diabetes			Open Wound/ Wound Care		
Recent Falls			Headaches		
Heart Disease			Fracture		
Current Chest Pain			Recurrent Kidney Infections		
CVA (Stroke)			Pregnant		
Seizure Disorder			Special Equipment (CPAP)		
Current Detox Symptoms?			Explain:		

Are you currently experiencing any medical complications? □ NO □ YES (If yes, staff contact physician/nursing)

Do you currently take medication? □ NO □ YES

Did you bring the medication with you today? □ NO □ YES

If you know them, please list medications below:	

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Patient Label

COMMUNICABLE DISEASE QUESTIONAIRE

NAME_____ DATE: _____

This brief questionnaire is a screening tool to help identify possible communicable diseases.

1. Do you currently have or have you ever had: OR Have you been vaccinated for:

Measles	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Mumps	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Rubella	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Influenza	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Chicken Pox	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Hepatitis A	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Hepatitis B	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
Hepatitis C	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	
HIV	☐ NO ☐ Yes	Date: _____		
Tuberculosis	☐ NO ☐ Yes	Date: _____		
Other:	☐ NO ☐ Yes	Date: _____	☐ NO ☐ Yes	Date: _____

2. Are you now under the care of a physician or taking any medication for a communicable disease?
☐ NO ☐ Yes (Please note any current treatment for any areas checked)_____

3. Have you had recent contact with someone with any of the above illnesses? ☐ NO ☐ Yes
If yes which one (s) and when: _____

4. Have you ever been tested for Tuberculosis? ☐ NO ☐ Yes If yes, when? (Date) _____

5. Have you ever been tested positive for TB? ☐ NO ☐ Yes
If yes, did you have a chest x-ray? ☐ NO ☐ Yes
Were you treated ? ☐ NO ☐ Yes If yes, when? (Date):_____
What kind of treatment?_____

6. Please check yes or no to ALL symptoms as they apply to you:

Productive cough (3 weeks or more)	☐ NO ☐ Yes	Persistent Weight Loss without Dieting	☐ NO ☐ Yes
Persistent Low Grade Fever	☐ NO ☐ Yes	Night Sweats	☐ NO ☐ Yes
Loss of Appetite	☐ NO ☐ Yes	Swollen Glands, usually in the Neck	☐ NO ☐ Yes

FOR STAFF USE ONLY

After review of answers, what actions were taken:
☐ None Needed
☐ Actions Needed Explain: _____

Vital Signs: BP: _____ Pulse: _____ Respirations: _____ Temp: _____ O2 Sat.:_____ Breathalyzer: _____

Reviewed By:_____ _____ _____
Signature of Staff Date Time