EMERGENCY PHONE TRIAGE CHECKLIST

Date/Time _____ Emp Initial _____

Patient Name _____ New / Prior

Date of birth _____ Phone _____

Which eye is affected? Right / Left / Both

Chief Complaint

When did the problem start? _____ ___ days

Onset: Sudden/Gradual

Changes Worse/Better/Stable

Associated symptoms:

Has there been a change in patient's vision? Yes / No

Distance/Near/Both

Floaters/Spots in vision? Description _____

Specific Injury? Yes/No Description _____

Pain? Yes/No

Describe pain from 1 (mild) to 10 (extreme, can't open) _____

Action Taken:

Scheduled? Immediate/Today/Next Available

Referred out? To _____

Doctor Call? DSR MJA LE CBW TH

Notes:

_____

_____

Patient's Medical Insurance _____

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