EMERGENCY PHONE TRIAGE CHECKLIST  Date/Time Emp Initial		EMERGENCY PHONE TRIAGE CHECKLIST		
	_		Emp Initial	
Patient Name	New / Prior	Patient Name	New / Prior	
Date of birth Phone		Date of birth Phone		
Which eye is affected? Right / Left / Both Chief Complaint		Which eye is affected? Right / Left / Both Chief Complaint		
When did the problem start? days			When did the problem start? days	
Onset: Sudden/Gradual		Onset: Sudden/Gradual		
Changes Worse/Better/Stable Associated symptoms:		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)		Specific Injury? Yes/No Description Pain? Yes/No		
Action Taken:		Action Taken:		
Scheduled? Immediate/Today/Next Available		Scheduled? Immediate/Today/Next Available		
Referred out? To		Referred out? To		
Doctor Call? DSR MJA LE CBW TH		Doctor Call? DSR MJA LE CBW TH		
Notes:		Notes:		
Patient's Medical Insuran	ace	Patient's Medical Insura	nce	