

Triage history

Patient ID

Date of triage.

Time of triage

Triage Category

 P1 P2 P3

Sex of the patient

 Male Female

Systolic Blood pressure

((in mm of Hg))

Diastolic Blood Pressure

((in mm of Hg))

Pulse

((in beats/min))

Temperature

(if patient is afebrile, please input 37.8 degrees Celsius)

((in degree celsius))

Respiratory rate

((in breaths/min))

Oxygen saturation

((%))

Date of birth of the patient?

Age of the patient

Chief complaint

- Chest pain, chest pressure, chest tightness
- Shortness of breath
- Headache
- Vertigo
- Nausea or vomiting
- Abdominal pain
- Discomfort (ghabrahat)
- Blurred vision
- Bilateral leg swelling
- Slurring of speech
- Facial deviation
- Altered mental state
- Decreased urine output
- Any unilateral / one sided limb weakness
- No symptoms (with high BP)
- Others

Chief complaint, others (Specify)

If pain was specified in any region, was the pain severity score taken?

- Yes
- Not documented

What is the severity of the pain?

 ((please enter a number between 0 to 10))

Did the patient receive any analgesia for the pain?

- Yes
- No
- Not documented

What analgesics did the patient receive?

	Yes, Oral	Yes, IV	No
Opioids (Tramadol, Nalbuphine/Kinz)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paracetamol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NSAIDS (Ketorolac, Naproxen, Diclofenac, Brufen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Others (Specify)

Assessments and examinations

What is the Systolic blood pressure at assigned bed?

((in mm/Hg))

What is the diastolic blood pressure at assigned bed?

((in mm of Hg))

What was the pulse at assigned bed?

((in beats/min))

What was the temperature (in degree Celsius) at assigned bed?

((in degree celsius))

What was the respiratory rate at assigned bed?

((in beats/min))

What was the oxygen saturation at assigned bed?

((%))

On CNS exam, were any new focal deficits found?

- Yes
 No
 Not documented

Was the GSC taken?

- Yes
 Not documented

What was the GCS?

On Chest exam, were any bilateral crackles heard?

- Yes
 No
 Not documented

On CVS exam. was the jugular venous pressure raised?

- Yes
 No
 Not documented

On CVS exam, were additional heart sounds heard or an S3 gallop heard?

- Yes
 No
 Not documented

On a CVS exam, did the patient have pedal edema?

- Yes
 No
 Not documented

Was a fundoscopy exam performed?

- Yes
 Not documented

Was papilledema noticed on the fundoscopy?

- Yes
- No
- Not documented

Past Medical History

Does the patient have any co-morbidities?

- Yes
 No
 Not documented

Please select the co-morbid conditions that the patient has.

	Yes	No	99 Not documented
Diabetes Mellitus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cerebrovascular accident/ stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ischemic Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic obstructive pulmonary disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interstitial lung disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dyslipidemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overweight/ obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking/exposed to second hand smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid disorders (Hyper and hypothyroidism)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"Others"
(Please specify)

Is the patient taking any anti-hypertensive medications or being prescribed any anti-hypertensive medications?

- Yes
 No
 Not documented

What anti-hypertensive medications is the patient taking or being prescribed?

	Yes	No	Not documented
Angiotensin converting enzyme (ACE) inhibitors (captopril, enalapril, lisinopril)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angiotensin II Receptor Blockers (ARB) (candesartan, valsartan, losartan, erbesartan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Calcium Channel Blockers (verapamil, amlodipine, nifedipine, diltiazem,)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beta Blockers (atenolol, propranolol, metoprolol, carvedilol, labetalol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hydralazine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diuretics (furosemide - Lasix, spironolactone, hydrochlorothiazide)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is the patient compliant to anti-hypertensive medications?
(taken within 24 hours) Yes No Not documented

Diagnostic tests

Creatinine? Yes
 No

Creatinine value _____

CBC? Yes
 No

Hemoglobin value _____

Hematocrit value _____

Platelet count value _____

BUN? Yes
 No

BUN value _____

Electrolytes - Sodium (Na)? Yes
 No

Sodium value _____

Electrolyte - Potassium (K)? Yes
 No

Potassium value _____

Electrolyte - Chloride? Yes
 No

Chloride value _____

Electrolyte - bicarbonate (HCO₃)? Yes
 No

Bicarbonate value _____

Coagulation profile - PT/ INR? Yes
 No

Prothrombin time _____

INR _____

Coagulation profile - APTT? Yes
 No

Activated partial thromboplastin time _____

1st troponin test? Yes
 No

1st troponin value? _____

2nd troponin test Yes
 No

2nd troponin value? _____

ECG performed? Yes
 Not found

	Yes	No
ST-T changes	<input type="radio"/>	<input type="radio"/>
LVH	<input type="radio"/>	<input type="radio"/>

Urine detail report performed? Yes
 No

Did the urine analysis show proteinuria? Yes
 No/ Negative

Urine Protein? _____

Did urine analysis show hematuria? Yes
 No/Nil

Hemoglobin in urine? _____

RBCs in urine? _____

Was chest xray ordered? Yes
 No

	Yes	No
Normal/unremarkable	<input type="radio"/>	<input type="radio"/>
Signs of fluid overload (Hilar congestion, pulmonary edema, upper lobe diversion, pulmonary vascular congestion)	<input type="radio"/>	<input type="radio"/>
Cardiomegaly	<input type="radio"/>	<input type="radio"/>

Was a CT scan of the head performed? Yes No

	Yes	No
Normal	<input type="radio"/>	<input type="radio"/>
Infarction	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>

Was an MRI of the brain/head performed? Yes No

	Yes	No
Normal	<input type="radio"/>	<input type="radio"/>
Infarction	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>

End organ damage

Was a diagnosis of end-organ damage made/ found?

- Yes
- No
- Not documented

End organ damage details

	Yes	No	Not documented
Heart (trop positive OR ST-T changes in ECG)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney (Proteinuria, raised creatinine)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eye (Papilledema)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brain (Stroke, sub-arachnoid hemorrhage, Hypertensive encephalopathy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Medication/ treatment/ interventions provided during stay

Were Per oral (PO) medications administered?

- Yes
- No
- Not documented

Angiotensin converting enzyme (ACE) inhibitors (captopril, enalapril, lisinopril)

- Yes
- No
- Not documented

Angiotensin converting enzyme dose?

Angiotensin II Receptor blockers (ARB) (candesartan, valsartan, losartan, erbesartan)

- Yes
- No
- Not documented

Angiotensin II receptor blockers dose?

Calcium channel blockers (Verapamil, amlodipine, nifedipine, diltiazem)

- Yes
- No
- Not documented

Calcium channel blockers dose?

Beta Blockers (atenolol, propranolol, metoprolol, carvedilol, labetalol)

- Yes
- No
- Not documented

Beta blockers dose?

Hydralazine

- Yes
- No
- Not documented

Hydralazine dose?

Diuretics (furosemide - lasix, spironolactone, hydrochlorothiazide)

- Yes
- No
- Not documented

Diuretics dose?

Were Intravenous (IV) medications administered?

- Yes
- No
- Not documented

Beta blockers (metoprolol, labetalol)

- Yes
 No
 Not documented

Beta blockers dose?

Calcium channel blockers (Verapamil, Diltiazem)

- Yes
 No
 Not documented

Calcium channel blockers dose?

Hydralazine

- Yes
 No
 Not documented

Hydralazine dose?

Diuretics (furosemide - Lasix, spironolactone, hydrochlorothiazide)

- Yes
 No
 Not documented

Diuretics dose

Infusion started

- Yes
 No
 Not documented

Nitrates (nitroprusside and glyceryl trinitrate (GTN))

- Yes
 No
 Not documented

Nitrate infusion dose?

Labetalol infusion

- Yes
 No
 Not documented

Labetalol infusion dose?

ER discharge/ disposition information

ER diagnosis?

ER disposition?

- Admitted
- Discharged
- Expired
- Left against medical advice
- Transfer out

Special Care (monitored bed)

- Yes
- No

Days in special bed?

((in days))

ICU/CCU

- Yes
- No

Days in ICU/CCU

((in days))

Ward

- Yes
- No

Days in ward

((in days))

Date of registration in ER

Time of registration in ER.
(24 hours)

Date of disposition from ER?

(if 'admitted', Source: ED assessment transfer out form)

Time of disposition in the ER?
(24 hours)

Date of hospital discharge
(Source: Discharge summary)

Time of hospital discharge
(24 hours)

Did the patient expire in the hospital during stay?

- Yes
- No

Where did the patient expire?

- ER
 Special Care
 ICU/CCU
 Ward
-

SBP at the time of disposition from the ER?

((in mm/Hg))

DBP at the time of disposition from the ER?

((in mm/Hg))

Were discharge instructions related to hypertension provided when the patient was discharged from the hospital?

- Yes
 No
 Not documented
-

Did the discharge instructions include any advice on life style modifications (e.g. low salt diet, exercise, etc.) ?

- Yes
 No
-

Low salt diet?

- Yes
 No
-

Exercise?

- Yes
 No
-

Quit smoking?

- Yes
 No
-

Did discharge instructions include B.P. monitoring advice?

- Yes
 No
-

Were anti-hypertensive medications prescribed on discharge from ER/ Hospital?

- Yes
 No
 Not documented
-

Please name the anti-hypertensive medications and their respective dosages.

Did discharge instructions include follow-up visit?

- Yes
 No
-

In which service specialty was the follow-up visit of the patient scheduled and when?

- Cardiology
 Internal medicine
 Family medicine
 ED Fast track
 Neurology
 Ophthalmology
 Others
-

Cardiology follow up days

Did patient come for the cardiology follow up visit?

- Yes
 No

What was the follow-up visit date for cardiology?

Internal Medicine follow up days

Did patient come for the Internal Medicine follow up visit?

- Yes
- No

What was the follow up visit date for Internal medicine?

Family Medicine follow up days

Did patient come for the family medicine follow up visit?

- Yes
- No

What was the follow up visit date for Family medicine?

ED Fast Track follow up days

Did patient come for the ED Fast Track follow up visit?

- Yes
- No

What was the follow up visit date for ED Fast Track?

Neurology follow up days

Did patient come for the neurology follow up visit?

- Yes
- No

What was the follow up visit date for Neurology?

Ophthalmology

Did patient come for the ophthalmology follow up visit?

- Yes
- No

What was the follow up visit date for Ophthalmology?

Others (please specify)

Others follow up days

Did patient come for the "Others" speciality follow up visit?

- Yes
- No

What was the follow up visit date for "Others" speciality?

Follow-up questionnaire

Date of Discharge

Date of follow up

Date of contact established?

Time of contact established?

Follow up event

- 1st month follow up
- 3rd month follow up
- 6th month follow up

Contact established?
(call made)

- Yes
- No

How many attempts were made to establish contact
(through telephonic call)?

- 1st attempt
- 2nd attempt
- 3rd attempt
- 4th attempt
- 5th attempt
- 6th attempt
- 7th attempt
- 8th attempt
- 9th attempt
- 10th attempt
- 11th attempt
- 12th attempt
- 13th attempt
- 14th attempt

Others, please specify

What were the reasons for no response?

- Phone engaged
- Phone switched off
- Not answering
- Invalid number
- Number exchanged
- Wrong number
- Others

Others, Please specify

How are you (is the patient) after getting discharged
from the hospital?

- Alive
- Dead

When did the patient expire?

What was the reason for death?

Where did the patient die?

- In hospital
- At home
- Others

Others (please specify).

Do you (the patient) regularly monitor your blood pressure readings?

- Yes
 No

How often do you get your blood pressure checked?

- Daily
 Twice a week
 Once a week
 Once a month
 Randomly
 On convenience basis (when someone available or BP apparatus is available)
 Rarely

Have you (the patient) tried reducing salt intake since diagnosed with high blood pressure?

- Yes
 No
 Unchanged (already using low salt in diet)
 Others

Others, please specify

Do you (the patient) do any physical activity (other than household chores) for at least 30 minutes a day? (E.g. walking, running, jogging, cycling, swimming, gym, etc.)

- Yes
 No

How often do you (the patient) do any physical activity?

- One day a week
 Two days a week
 Three days a week
 Four days a week
 Five days a week
 Six days a week
 Seven days a week (daily)

What other exercise or physical therapy do you (the patient) do?
E.g. yoga, stretching
(Please specify)

Since diagnosis with high blood pressure, did you (the patient) smoke cigarettes?

- Yes
 No
 Never smoked

How often do you (the patient) smoke cigarettes?

- Daily
 Not daily
 Occasionally

Were you (the patient) prescribed any blood pressure medications after discharge from the hospital?

- Yes
 No

Are you (the patient) taking those medications regularly?

- Yes
 No
 Never

Did you (the patient) visit or follow up with your doctor related to blood pressure?

- Yes
 No

Please specify how often it was?

Visited once after discharge
 Visited twice after discharge
 Visited more than twice after discharge (around once a week)

Have you (the patient) developed or suffered from any other illness because of hypertension?

Yes
 No

What was the illness?

Stroke
 Heart attack
 Kidney disease
 Eye disease
 Other illness or condition

Other illness or condition
(please specify)

Were you (the patient) admitted again since your discharge from the Aga Khan University?

Yes
 No

What was the reason for your admission to the hospital?

High blood pressure
 Chest pain
 Heart attack
 Stroke, one sided weakness
 Headache
 Kidney failure
 Others

Others
(Please specify)
