

Patient name:	Patient number:	Male / Female	Age	Ht. (cm)	Wt. (kg)	Date:	Time in:	Time out:
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<input type="checkbox"/> COPD/Asthma
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Pulmonary edema
<input type="checkbox"/> Pneumothorax
<input type="checkbox"/> ARDS
<input type="checkbox"/> Other: <input style="width:50px;" type="text"/>

<input type="checkbox"/> ACS
<input type="checkbox"/> Shock
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cardiac Arrest
<input type="checkbox"/> Tachyarrhythmia Bradyarrhythmia
<input type="checkbox"/> Other: <input style="width:50px;" type="text"/>

<input type="checkbox"/> Coma
<input type="checkbox"/> TBI
<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Status Epilepticus
<input type="checkbox"/> Other: <input style="width:50px;" type="text"/>

<input type="checkbox"/> Acute abdomen
<input type="checkbox"/> GI bleeding
<input type="checkbox"/> Liver failure
<input type="checkbox"/> Renal failure
<input type="checkbox"/> DKA
<input type="checkbox"/> VTE
<input type="checkbox"/> Infection/Sepsis
<input type="checkbox"/> Other: <input style="width:50px;" type="text"/>

↑ HR <input style="width:50px;" type="text"/> ↓	↑ BP <input style="width:50px;" type="text"/> ↓	↑ RR <input style="width:50px;" type="text"/> ↓	↑ SpO ₂ <input style="width:50px;" type="text"/> ↓	↑ Temp <input style="width:50px;" type="text"/> ↓	Pain (0-10) <input style="width:50px;" type="text"/>	UO (ml) <input style="width:50px;" type="text"/>
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A	<input type="checkbox"/> Airway compromise	B	<input type="checkbox"/> Poor air entry	C	<input type="checkbox"/> Sinus rhythm	D	<input type="checkbox"/> Awake	E	<input type="checkbox"/> Gastro Intestinal	<input type="checkbox"/> Bleeding					
	<input type="checkbox"/> Stridor		<input type="checkbox"/> Crackles		<input type="checkbox"/> ST changes		<input type="checkbox"/> Verbal		<input type="checkbox"/> Abd. Distension	<input type="checkbox"/> Skin					
	<input type="checkbox"/> Wheezing		<input type="checkbox"/> Work of breathing		<input type="checkbox"/> AV block		<input type="checkbox"/> Painful		<input type="checkbox"/> Peritoneal signs	<input type="checkbox"/> Rash					
HIV		TB		SARS		Influenza		C		D		E			
Incharge		Physician:								C		D		E	
		Nurse:													
		Resident/Fellow:													
		<input type="checkbox"/> Atrial fib.			<input type="checkbox"/> V tach			<input type="checkbox"/> Unresponsive			<input type="checkbox"/> Delirium			<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Wound
		<input type="checkbox"/> Weak pulse			<input type="checkbox"/> Mottling			<input type="checkbox"/> Seizure			<input type="checkbox"/> Focal deficit			<input type="checkbox"/> Vomiting	<input type="checkbox"/> Jaundice
								<input type="checkbox"/> Hematemesis					<input type="checkbox"/> SC. emphysema	<input type="checkbox"/> Edema	

↑WBC↓	↑Hb↓	↑Pit↓	↑INR↓	↑Glu↓	↑Na↓	↑K↓	↑Ca↓	↑pH↓	↑PO ₂ ↓	↑PCO ₂ ↓	↑HCO ₃ ↓	↑Lac↓	↑Billi↓	↑BUN↓	↑Cr↓
<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>

Reason for Admission		History		Code Status	Allergies	Medications	
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Seizure	<input type="checkbox"/> Unknown	<input type="checkbox"/> Cancer	<input type="checkbox"/> Full code	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Beta blockers
<input type="checkbox"/> Altered mental state	<input type="checkbox"/> Focal deficit	<input type="checkbox"/> Previously healthy	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> DNI	<input type="checkbox"/> No allergies	<input type="checkbox"/> No medications	<input type="checkbox"/> Steroids
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Postoperative	<input type="checkbox"/> CHF	<input type="checkbox"/> AIDS	<input type="checkbox"/> DNR	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Opioids	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Cardiac arrest	<input type="checkbox"/> Other:	<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Other:	<input type="checkbox"/> DNI & DNR	<input type="checkbox"/> Other:	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Bleeding	<input style="width:100px;" type="text"/>	<input type="checkbox"/> Chronic liver failure	<input style="width:100px;" type="text"/>	<input type="checkbox"/> Unknown	<input style="width:100px;" type="text"/>	<input type="checkbox"/> Anticoagulants	<input type="checkbox"/> Other:
<input type="checkbox"/> Hypotension		<input type="checkbox"/> Chronic renal failure		<input type="checkbox"/> Antihypertensives			
<input type="checkbox"/> Arrhythmia		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Insulin			

Findings	Medication/Interventions	Ordered	Completed	Medication/Interventions	Ordered	Completed
ECG:		:	:		:	:
US:		:	:		:	:
CXR:		:	:		:	:
CT:		:	:		:	:
Other:		:	:		:	:
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Whiteboard