DOC Rapid Triage Form for PHSS Transfer

Last Name: _____ First Name: _____ Date: _____

Allergies: _____ Age: _____

Triage Tag #: _____ DOB: _____ Male ☐ Female ☐

Circle one or more in each column

Type	Acute Stabilization Required (To Closest ER)	Possible Specialty Care Needs (Definitive Care Facility)
1. Obstetrical 2. Newborn or Infant 3. Pediatric 4. Medical 5. Psychiatric 6. Surgical 7. Trauma 8. Other _____	1. Hemorrhage 2. Hemodynamic instability 3. Cardiac instability 4. Respiratory instability 5. Neurological instability 6. Severe trauma 7. Psychiatric 8. Other _____ 9. Not Needed	1. Orthopedic 2. Neurosurgical 3. Urology 4. General surgery 5. Medical critical care 6. Obstetrical care 7. High risk obstetrical care 8. Pediatric 9. Pediatric intensive care 10. Neonatal intensive care 11. Burn 12. Psychiatry 13. Dialysis dependent 14. Immune compromise 15. Isolation / contagious 16. Other _____ 17. No special needs

VITAL SIGNS	Pulse	BP	Respiration	Temp

Description

_____

_____

_____

_____