

24 Hour Triage Rapid Assessment and Access Toolkit for Children and Young People V2 (2020) Log Sheet

Hospital name and department:

Patient details	Patient history	Enquiry details
Name: <input type="text"/>	Diagnosis (Inc. other diagnoses / co-morbidities):	Date: <input type="text"/> Call start time:
NHS no: <input type="text"/>		Who is calling?
Hospital no: <input type="text"/>	Male <input type="radio"/> Female <input type="radio"/>	What phone number do you want us to call back on?
DoB: <input type="text"/>		Reason for the call (in caller's own words):
Age: <input type="text"/>	Consultant team:	
Phone no: <input type="text"/>		

What treatment is the patient receiving? (Please tick below)

Chemotherapy (incl. oral maintenance) Immunotherapy Car-T Radiotherapy Post Stem Cell Transplant Surgery None

When did the patient last receive treatment?:

What is the patient's temperature?: °C **please note that hypothermia is a significant indicator of sepsis**

When was the patient last discharged / reviewed? Have you called any other healthcare professional in the last 48 hours? Yes* No

Does the patient have a central line? Yes N Does the patient have a shunt / Ommayer Reservoir / other medical device? Yes N

Advise <input type="radio"/> Follow up/review <input type="radio"/> Assess <input type="radio"/> REMEMBER two or more amber = RED	Please document current medication	Please document significant medical history: (Include last FBC if known and date taken, and *detail of any recent calls)
Fever <input type="radio"/>		
Infection <input type="radio"/>		
Shortness of breath / difficulty breathing <input type="radio"/>		
Bleeding and / or bruising <input type="radio"/>		
Neurosensory / Neuromotor <input type="radio"/>		
Activity <input type="radio"/>		
Pain <input type="radio"/>		
Rash and / or infectious disease contacts <input type="radio"/>		
Nausea, eating, drinking <input type="radio"/>		
Vomiting <input type="radio"/>		
Mucositis <input type="radio"/>	Action taken / advice given:	
Urinary output <input type="radio"/>		
Diarrhoea <input type="radio"/>		
Constipation <input type="radio"/>		
Other (please state) <input type="text"/>	Attending for assessment at:	Receiving team notified: Yes <input type="radio"/> N <input type="radio"/> Call end time:

Triage practitioner details

Signature: <input type="text"/>	Designation:
Print name: <input type="text"/>	Date: <input type="text"/>

Review of actions taken: (Review no later than 24 hours after call. Single Ambers require earlier call back)

Signature: <input type="text"/>	Designation:
Print name: <input type="text"/>	Date: <input type="text"/>

Hospital logo:

