

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

