



**Central Montana Medical Center**  
408 Wendell Ave., Lewistown, MT 59457

Current Date: 042717 Current Time: 1008

**EMERGENCY ROOM RECORD MR-2A**

Patient Name:  Account #:  MR #:  DOB:  Age:   
Gender:

Weight  New

Allergy	Reactions
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

More Allergies

LATEX ALLERGY

**Medication Reconciliation**

Condition on Arrival:  Trauma  Illness  Triage Level  I=Emergent  II=Urgent  III=NonUrgent

Accident:  Yes  No

Mode of Arrival:  EMS/Stretcher  Wheelchair  Carried  Walked  Alone  w/Family  w/Friend  
 w/other  Brought in by Law Enforcement  Sheriff  Police  Other

Patient received from the following EMS Service

PreHospital Notification:  Yes  No

Chief Complaint

ADMISSION GLASCOW COMA SCORE

**ADMISSION VITAL SIGNS**

Time:  Pulse:  R:  BP:  Position:  BP Site:

SaO2:  Temp:  Method:

Pain:  (Pain Faces) Location:  Onset:  Intensity

Duration:

More VS

OB/GYN History LMP:  G:  P:  Ab:   Lactating  Pregnant EDD:

Birth Control:  Oral Contraceptive  Condom  IUD  Tubal Ligation  Hysterectomy Other:

**MEDICAL HISTORY**  Unknown  None

Asthma  Cancer  Cardiac  CHF  COPD  CVA/TIA  Dementia  Diabetes  
 Drug/ETOH  HTN  Pacemaker/ICD  Psychiatric  Renal Failure  Seizures

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGERIES: Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Travel in last 21 days?  Yes  No Where

Contact with person with highly contagious disease?  Yes  No

If patient actively ill with suspected infectious disease:

Refer to HAN Reports

- cdc.gov
- Inform Public Health before discharge

**DNR STATUS:**

**IMMUNIZATIONS UP TO DATE?**  Yes  No **Date of Last Tetanus:**

**IV STARTS**

#1 IV Started Time  IV Catheter Size 14-18  IV Catheter Size 20 - 24  IV Ultrasound Needle   
IV Site  IV Successful  Yes  No

#2 IV Started Time  IV Catheter Size 14-18  IV Catheter Size 20 - 24  IV Ultrasound Needle   
IV Site  IV Successful  Yes  No

#3 IV Started Time  IV Catheter Size 14-18  IV Catheter Size 20 - 24  IV Ultrasound Needle   
IV Site  IV Successful  Yes  No

Lab Here

To x-ray per  accompanied by  Time

Returned from x-ray Time:

To x-ray per  accompanied by  Time

Returned from x-ray Time:

To x-ray per  accompanied by  Time

Returned from x-ray Time:

To x-ray per  accompanied by  Time

Returned from x-ray Time:

To x-ray per  accompanied by  Time

Returned from x-ray Time:

O2 on per  L/min  Time

EKG per ER Nurse #1  EKG per ER Nurse #2  EKG per ER Nurse #3

EKG per CPC #1  EKG per CPC #2  EKG per CPC #3

Cardiac Monitor

Warming Measures On Time:   Lights  Fluids  Blanket  Bair-hugger

**Emergency Room Physician:**  **Family Physician:**  **Time Physician Notified:**

**Time Physician Here:**  **Time of Consult:**  **Time Orders Received:**

**Possible Stroke Admission (click here)**

NIH Score:  TIMI Score:  Stroke Exclusion Form  Yes  No

Neuro Consult Date:  Time

**Do you use tobacco?**  Yes  No **Do you use street drugs?**  Yes  No **Do you drink?**  Yes  No

Date  Time

NARRATIVE

Lined area for narrative text.

VITAL SIGNS							
Time	BP	Pulse	Resp	Temp	SaO2	Pain	Blood Glucose
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**Output**

Foley Time:  Size:  Amt Out of Foley:  Irrigation Amount:   
 Voided Time:  Amount:  Time:  Amount:  Time:  Amount:   
 NG Time:  Size:  Amt Out of NG:  Emesis Amount:   
 Lavage Fluid:  Amount:  Irrigation Amount:

Total Output:

**DISCHARGE GLASCOW COMA SCALE**

**DISCHARGE VITAL SIGNS**

Time:  Pulse:  R:  BP:  Position:  BP Site:   
 SaO2:  Temp:  Method:   
 Pain:  (Pain Faces) Location:  Onset:  Intensity:   
 Duration:   
 More VS

**Valuables:**  Watch  Glasses/Contacts  Wallet  Dentures  Ring  Hearing Aids    
**Location of Valuables:**  Patient  Family/SO  Safe  Other

**DISCHARGE/TRANSFER/ADMISSION**

**Referral/Transition of Care**

Admission Decision Date:  Admission Decision Time:   
 Discharge From ER Date:  Discharge from ER Time:   
 Condition:  Unchanged  Improved  Stable  Other:   
 Discharged To:  Private Car  Doctor's Office  Police  Funeral Home Facility:   
 **ER Nurse Contacted Transfer Facility**  
 Acute Care Room #   High Acuity Room #   OB Room #:   OR  
 By:  EMS/Stretcher  Wheelchair  Carried  Walked  Alone  w/Family  w/Friend(s)  
 w/other   Pt. left w/o being seen by MD  AMA  
 Aftercare Instruction Sheet Given:  Patient Voices Understanding of Discharge Instructions  
 Follow-up Care Ordered for Discharge

Nurses Signature:   
 Date:  Time:

Nurses Signature:

Date:

Time:

Revised: 09/22/2014 DKJ/ 07/29/2015 DKJ 12/21/2015 DKJ 01/28/2016 DKJ 02/04/2016 DKJ 08/01/2016 DKJ  
Revised 08/18/2016 DKJ Revised 09/13/2016 DKJ