HOSPITAL:____________________CHIEF COMPLIANT____________MEDICAL RECORD #______________

DATE OF ADMISSION:___________________AGE:___________SEX:__________MD REVIEWER:____________

REVIEW CATEGORY	MET	NOT MET	N/A	NOTES	REVIEW CATEGORY	MET	NOT MET	N/A	NOTES
Mode of arrival					**Labs**				
Triage time and assessment					**Medications – Response to Treatment**				
Triage Level/Acuity					**Time of and type of IV**				
Initial vital signs Immunization Status					**Time and type of consultant notified**				
Weight - kg					**Time consultant responded**				
Time of evaluation by MD					**Time and type of transport team notified**				
Nursing Assessment / Re-Assessment					**Time transport team arrived / departed:**				
Physician Assessment/ Re-Assessment					**Transfer Forms on chart**				
Pulse oximetry					**Serial examinations**				
Oxygen delivery/type					**Child Abuse forms, &/or referral# /notification.**				
X-Rays					**Time Law Enforcement or DCFS notified**				
P.O. fluid challenge I&O					**Disposition/Condition/Vital Signs**				
Procedures					**Patient teaching After care instructions**				

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