Department of Health Government of Nunavut	Title **Infant - Telephone Triage and Infant Assessment (Age 0 – 12 Months)**		
NURSING POLICY, PROCEDURE AND PROTOCOLS		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Clinical Practice	07-029-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 18, 2017	August 2020	07-006-00 Telephone Triage 07-007-00 Telephone Advice 07-008-00 Acutely Ill Infants	3
APPLIES TO:			
All Community Health Nurses and Nurse Practitioners			

1. BACKGROUND:

Community Health Nurses and Nurse Practitioners provide telephone triage services within the community to assess the severity of the client's symptoms and determine the appropriate plan of care. The health status of infants can quickly deteriorate, lending to the need that all ill infants require full assessments at the Health Centre to determine the infants' health status and appropriate plan of care.

2. POLICY:

ASSESSMENT:

2.1 All infants aged 12 months and under must be fully assessed in the clinic, whether it is during or after regularly scheduled clinic hours.

TELEPHONE TRIAGE:

2.2 Infants aged 12 months and under must be seen in the health centre within one hour of receiving a phone call from the parent/guardian. The timing of the visit to be determined by the urgency of the reported signs and symptoms.

i. If the parent/guardian declines to bring the infant to the health centre at the time of the call, he/she must be (1) offered the opportunity to call the Nurse-on-Call back and (2) offered an appointment at the health centre later that same day or the following calendar day.

2.3 Every telephone call received regarding an infant must be documented on the *Infant Telephone Triage Form* at the time the call is received. The only exception to this policy statement is when the nurse has the infant's chart in his/her possession at the time of the call and the information is written directly into the health record.

3. PRINCIPLES:

3.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by Registered Nurses during telephone triage require complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and normal growth and development for all age groups in order to accurately understand the client's presenting symptoms.

3.2 All parents/guardians have a right to refuse to bring the infant to the health centre to be assessed. In these situations, the nurse will attempt to obtain as much information as possible over the phone to mitigate the risks associated with not immediately assessing the infant in the clinic.

3.3 The *Infant Telephone Triage Form* is a legal document and must be promptly secured in the health record.

4. DEFINITIONS:

Nurse: For the purpose of this policy, nurse refers to Community Health Nurses and Nurse Practitioners.

Telephone Triage: an assessment over the phone to assess a health condition of a client in order to determine the level of urgency for care and the overall plan of care.

5. PROCEDURE:

Telephone Triage:

5.1 When a call is received from a parent / guardian regarding an infant, the nurse shall use the *Infant Telephone Triage Form* to guide the telephone assessment, determine the urgency, and to record the details of the call.

NOTE: The triage form is only intended to provide guidance for a preliminary evaluation of the infant's health status to determine the urgency of receiving medical care. It is NOT intended to provide guidance for a full infant assessment.

5.2 The nurse will request that the parent/guardian bring the infant to the health centre within one hour of receiving the call. The decision to see the infant immediately versus safely postponing the clinic visit for one hour shall be based on the evaluation of the Infant's Airway, Breathing and Circulation status over the phone.

Note: In the event of a blizzard, safety considerations for the nurse and the client must be carefully evaluated. If the client's condition is determined to be non-urgent and it is not safe to travel to the health centre (e.g. zero visibility), the nurse must notify the SCHP and arrange appropriate follow up care (for example: follow up phone calls with the parent/caregiver at set intervals) until such time that the weather improves (e.g. visibility > 400m) or the client's condition changes and is now determined to be urgent or emergent. Follow local health centre protocols for travelling to the health centre in the event the client's condition is determined to be emergent or urgent, which includes notifying the SCHP of the situation before traveling to the health centre. Whenever the nurse is in doubt about the level of urgency for the client to be seen, the physician and supervisor are to be consulted.

5.3 If the parent/guardian declines to bring the infant to the health center, the nurse shall:

i. Obtain additional information regarding the infant's health status to support the development of an appropriate plan of care;
ii. Document details of the call on the triage form:
   - reason caller declined to attend health centre;
   - health status of the infant;
   - treatment plan;
   - date/time follow up appointment arranged
   - advice on when the parent/guardian should call the nurse on call back; and
   - any other relevant details discussed;
iii. Offer the caller an opportunity to call the nurse on call back at any time;
iv. Arrange an appointment for the infant to be assessed in the health centre later that day or on the next calendar day;
v. Complete, sign and date the *Infant Telephone Triage Form* at the time of the call and place in the infant's health record as soon as it is feasible to do so.

Assessment:

5.4 The assessment of the ill infant shall, at minimum, include ALL of the following:

1.	Undress the child down to his/her diaper.
2.	Address any airway, breathing or circulation issues first.
3.	Perform a full set of vital signs including temperature, heart rate, blood pressure, respiratory rate, oxygen saturation.
4.	Weigh the infant naked at <u>each</u> visit

5. Obtain a comprehensive history including: - past medical history and social history, - medications the infant has received (including antipyretics), - history of presenting illness, focusing on: when the illness started, if it's getting better or worse, if the infant is drinking, and voiding, and if there have been any changes in the level of alertness of the infant.
6. Perform a physical exam with particular focus on: - assessing hydration status (tears when crying, moist mucous membranes), - work of breathing, - fever status, - finding the focus: head and neck examination including looking in both ears and throat, respiratory exam (documenting work of breathing and breath sounds), cardiac exam, abdominal exam, dermatology exam and neurology exam including any signs of nuchal rigidity, and decreased level of consciousness. - Additional diagnostic tests may be required depending on the presenting concerns and initial assessment findings
7. Consult the physician on call for further advice (as per local protocols) for all concerns which arise from the assessment.

6. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Policy 06-009-00	Documentation Format

7. **REFERENCES :**

American Heart Association (2011) Pediatric Advanced Life Support Provider Manual

Approved By: Colleen Stockley	Date: Aug 18/17
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: August 18/17
Jennifer Berry, Chief Nursing Officer	

Department of Health Government of Nunavut Policy 07-027-00	TITLE **INFANT TELEPHONE TRIAGE FORM** **Age 0- 12 months**

ALL INFANTS (12 mths of age and younger) MUST BE ASSESSED AT THE HEALTH CENTRE

*** This Form is not to be used as an assessment of the infant but to establish URGENCY whether to see the child at the Health Centre immediately or within ONE hour ***

Name of Caller:	**Date**:	**Time**:	**Phone**:
Relationship of Caller to Patient:		**Location of Caller:**	
Name of Patient:	**Gender:** M / F	**Age**:	
Chief Complaint:			
Known Health Conditions:			

AIRWAY :			**CIRCULATION**		
Is the child breathing?	**Y**	**N**	Colour: ☐ **Normal** ☐ **Pale**		
Noisy Breathing?	**Y**	**N**	Urine Output : # wet diapers? _____ Last wet diaper? _____		
Is it worsening?	**Y**	**N**	Child crying /making tears?	**Y**	**N**
BREATHING			**DISABILITY**		
How is the infant's breathing? ☐ **Normal** ☐ **Fast** ☐ **Difficult**			Is the Child alert?	**Y**	**N**
Any blue colour around lips, hand or feet now?	**Y**	**N**	Responsive?	**Y**	**N**
Any previous episodes of blue colour around lips, hands or feet?	**Y**	**N**	Excessively sleepy?	**Y**	**N**
Using belly muscles while trying to breath?	**Y**	**N**	Irritable?	**Y**	**N**
Is the infant's head moving up & down when trying to breath?	**Y**	**N**	**Any other concerns?**		
Are the infant's nostrils moving in and out when trying to breath?	**Y**	**N**			

ASSESSMENT : Emergency: _____ Urgent (1 hour): _____ To Come to Clinic : Now _____ / within 1 hour_____

Other Comments : ☐ caller agreeable ☐ caller refused (check one)

If caller declines to bring child to health centre within one hour, DOCUMENT all advice given:

_____

_____

_____

_____

_____

_____

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut	TITLE **Pediatric and Adult - Telephone Triage**		
NURSING POLICY, PROCEDURE AND PROTOCOLS		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Clinical Practice	07-030-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 18, 2017	August 2020	07-006-00 Telephone Triage 07-007-00 Telephone Advice	6
APPLIES TO:			
All Community Health Nurses and Nurse Practitioners			

1. BACKGROUND:

Community Health Nurses and Nurse Practitioners provide telephone triage services within the community to assess the severity of the client's symptoms and determine the appropriate plan of care.

2. POLICY:

2.1 All clients who call regarding a health concern will be assessed on an individual basis utilizing the *Pediatric Telephone Triage Form* or the *Adult Telephone Triage Form* to establish the time frame in which the client will be assessed in the Health Centre.

2.2 **The following individuals** shall be offered to be seen at the Health Centre to have their presenting health concern fully assessed in the clinic immediately or within 4 hours based on the urgency of the presenting symptoms from the telephone triage:

1. All clients whose condition is determined to: a. Require resuscitation; b. Be emergent; or c. Be urgent
2. All clients age 65 and older;
3. All pregnant women;
4. All women up to two (2) weeks postpartum;
5. All clients who were discharged in the last 48 hour from a hospital or care facility;
6. All clients who had a surgical procedure under general anaesthetic within the previous ten (10) days
7. All clients who had an endoscopic procedure (gastroscopy or colonoscopy) within the previous three (3) days
8. All clients with complex medical condition(s)
9. All clients who had multiple visits or multiple calls to the Health Centre in the previous seventy-two (72) hours with the same presenting complaint(s)
10. All clients in custody of the RCMP when an Officer contacts the health centre regarding a health concern of a detainee.

2.3 Every telephone call received regarding a presenting health concern is to be documented on the appropriate *Telephone Triage Form* at the time the call is received. The only exception is when the nurse has the client's medical record in his/her possession at the time of the call and the information is written directly into the health record.

3. PRINCIPLES:

3.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by Registered Nurses during telephone triage require complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and

normal growth and development for all age groups in order to accurately understand the client's presenting symptoms.

3.2 Telephone Advice Guidelines are included in Appendix A and provide examples of strategies to mitigate the risks associated providing advice over the phone.

3.3 All clients have a right to refuse to be seen at the health centre to be assessed. In these situations, the nurse will attempt to obtain as much information as possible over the phone to mitigate the risks associated with not being assessed in the clinic.

3.4 The *Telephone Triage Forms* are legal documents and must be promptly secured in the client's health record.

4. DEFINITIONS:

Nurse: For the purpose of this policy, nurse refers to Community Health Nurses and Nurse Practitioners.

Telephone Triage: an assessment over the phone to assess a health condition of the client in order to determine the level of urgency for care and the overall plan of care.

Resuscitation: When there are conditions that are threats to life or limb or there is an imminent risk of deterioration which requires aggressive interventions (Canadian Triage and Acuity Scale (CTAS, 2007)).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Cardiac arrest
- Active seizures
- Respiratory arrest
- Major trauma (shock)
- Shortness of breath (severe respiratory distress)
- Altered level of consciousness (Glasgow Coma Scale 3-9)
- Severe dehydration in pediatric client

Emergent: When there are conditions that are potential threat to life, limb or function, requiring rapid medical intervention (CTAS, 2007).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Chest pain with cardiac features
- Hypothermia
- Fever (Temperature > 38.5, appears septic; and/or infant less than 3 months with fever >38 C)
- Headache (sudden, severe)
- Bizarre paranoid behavior
- Depression/suicide (attempted suicide, clear plan)
- Chemical exposure to eye
- Shortness of breath (moderate respiratory distress)
- Abdominal pain (severe pain)
- Altered level of consciousness (Glasgow Coma Scale 10-13)
- Moderate dehydration in pediatric client

Urgent: When there are conditions that could potentially progress to a serious problem requiring emergency intervention (CTAS, 2007).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Seizures (resolved, normal level of alertness)
- Diarrhea (uncontrolled bloody diarrhea)
- Active labour; premature rupture of membrane; and/or preterm bleeding after 20 weeks gestation.
- Depression / suicide (suicidal ideation, no plan)
- Shortness of breath (mild respiratory distress)
- Abdominal pain

- Headache (moderate pain 4-7 / 10)
- Chest pain, non cardiac features (other significant chest pain)

5. PROCEDURE:

5.1 When a call is received from a client the nurse shall use the appropriate *Telephone Triage Form* (Pediatrics or Adults) to guide the telephone assessment, determine the urgency, and to record the details of the call.

NOTE: The triage form is only intended to provide guidance for a preliminary evaluation of the client's health status to determine the urgency of receiving medical care. It is NOT intended to provide guidance for a full client assessment.

5.2 After analyzing the assessment information obtained from the telephone triage and noting the **required client populations to be seen listed in policy statement 2.2,** the nurse will determine the appropriate follow up plan:

i. Arrange to see the client at the Health Centre immediately or within four hours of the call; or
ii. Offer an alternate appointment date / time; or
iii. Provide telephone advice only.

Note: In the event of a blizzard, safety considerations for the nurse and the client must be carefully evaluated. If the patient's condition is determined to be non-urgent and it is not safe to travel to the health centre (e.g. zero visibility), the nurse must notify the SCHP and arrange appropriate follow up care (for example: follow up phone calls with the client/parent/caregiver at set intervals) until such time that the weather improves (e.g. visibility > 400m) or the patient's condition changes and is now determined to be urgent or emergent. Follow local health centre protocols for travelling to the health centre in the event the patient's condition is determined to be emergent or urgent, which includes notifying the SCHP of the situation before traveling to the health centre. Whenever the nurse is in doubt about the level of urgency for the patient to be seen, the physician and supervisor are to be consulted.

5.3 When a client declines to come to the health centre or when an alternate date/time has been arranged, the nurse shall:

i. Obtain additional information regarding the client's health status to support the development of an appropriate plan of care;
ii. Offer the caller an opportunity to call the nurse on call back at any time
iii. Counsel the client on when he/she should call the nurse on call back;
iv. Arrange an alternate appointment date/time;
v. Complete, sign and date the *Telephone Triage Form* and secure in client's health record as soon as it is feasible to do so.

5.4 Details of the call are to be documented on the *Telephone Triage Form* at the time the call is received and secured in the client's medical record at the earliest opportunity.

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Appendix A:	Telephone Advice Guidelines
Appendix B:	*Pediatric Telephone Triage Form*
Appendix C:	*Adult Telephone Triage Form*
Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Policy 06-009-00	Documentation Format

7. **REFERENCES:**

Canadian Emergency Department (2007). Canadian Triage and Acuity Scale (CTAS).

National Emergency Nurses Affiliation (2002). Position Statement A-1-4.

Approved By: Colleen Stockley	Date: Aug 18/17
Colleen Stockley, Deputy Minister, Department of Health	
Approved By:	Date: August 18/17
Jennifer Berry, Chief Nursing Officer, Department of Health	

Appendix A: Telephone Advice Guidelines

BACKGROUND:
It is within the scope of practice for a Community Health Nurses to provide telephone advice. The Department of Health supports the practice of providing telephone advice to clients by Registered Nurses.

Guidelines:

Common Hazards

The Registered Nurse must be aware of the most common hazards in giving telephone advice and attempt to eliminate these hazards. These include, but are not limited to:

Common Hazards	
▪ Using leading questions	▪ Using medical jargon
▪ Inadequate data collection	▪ Inadequate time to explore client's symptoms
▪ Jumping to conclusions	▪ Stereotyping callers or problems
▪ Failing to talk directly to the client	▪ Accepting client self-diagnosis and second guessing
▪ Overreacting and underreacting	▪ Nurse fatigue
▪ Language barriers	

Documenting Telephone Advice

Documenting the telephone call is a legal and professional obligation for the Registered Nurse who provides telephone advice to a client. The minimum requirements to be included in telephone contact documentation include:

Documentation	
▪ Date and time of the call	▪ Callers name, telephone number and address
▪ Information received from the caller	▪ Advice or information given by the nurse
▪ Referral and follow-up information	▪ Name of the nurse
▪ Client's name if different from caller	

The nurse may document the details of the telephone contact directly into the progress notes of the client's health record if immediately available. If the chart is not immediately available, such as when the nurse on call is fielding telephone calls outside the health centre, the nurse shall document the telephone conversation onto the appropriate *Telephone Triage Form*. At first opportunity, the form must be placed in the client's health record. Until such time, all forms must be kept secure while in the nurse's possession.

Risk Management

Providing telephone advice is a high risk activity. The following risk management strategies are designed for both the employee and employer and intended to reduce the incidence of injury to clients and the risk of potential liability:

Risk Management Strategies	
▪ When in doubt, see the client	▪ If a client calls seeking advice about the same problem more than once in the span of 3 days, then arrange for the client to be seen
▪ After reviewing care advice, ask the caller, "do you feel comfortable with this plan?" if the caller does not, schedule a call back in 1 hour or arrange to see the client. Remember telephone triage is point of entry into the health care system. Do not use triage as a method of limiting access. Instead use it as a method of improving access to primary care.	▪ Encourage callers to call back if the condition worsens. Callers should be given specific reasons to call back. At the least, the nurse should instruct the caller to call back if the "client becomes worse".

Appendix A: Telephone Advice Guidelines

▪ Establish policies and protocols for nursing staff regarding telephone triage and telephone advice	▪ Ensure nurses have appropriate training, skills and experience to provide telephone advice
▪ Establish a policy to protect patient confidentiality	▪ Provide adequate staffing
▪ Develop an appropriate documentation system, including safe management of all records	▪ Follow professional guidelines and standards
▪ Ongoing review and evaluation of protocols for relevancy and accuracy	▪ Conduct routine chart audits
▪ Report and follow-up unusual occurrences	

Communication Device

- Every attempt should be made to talk with clients using a land line.
- There are special circumstances when a land line is not possible, e.g. clients in outpost camps using hand radios and satellite phones.
  - ➢ Clients must be informed that the information discussed may not be confidential as others may be able to hear the conversation.
  - ➢ Obtain only as much information that is required to make a sound clinical judgment
  - ➢ Protect the client's identity and personal information as reasonably possible.

REFERENCES:

Canadian Nurses Association (2007). *Telehealth: The role of the nurse.* Ottawa, ON.

Canadian Nurses Protective Society (2008). *Info Law a Legal Information Sheet for Nurses: Telephone advice.* Ottawa, ON.

College of Nurses of Ontario (2009). *Telephone Practice Guideline*. Toronto, ON

Wilson, B. (2003). Telephone Advice. *Nursing BC, June, 27-28.*

Appendix B: Pediatric Telephone Triage Form

See separate document – note this form must be printed double sided

Appendix C: Adult Telephone Triage Form

See Separate document – note this form must be printed double sided

Department of Health Government of Nunavut Policy 07-030-00	**TITLE** **PEDIATRIC TELEPHONE TRIAGE FORM** **12 months to 12 years of age**

Infants 12 mths or younger TO BE SEEN AT THE HEALTH CENTRE - Use Infant *Telephone Triage Form*

Name of Caller:	**Date**:	**Time**:	**Phone**:
Name of Patient:	**Gender:** M / F	**Age / DOB**:	
Relationship of caller to patient:		**Location of caller:**	
Chief Complaint:			
Known Health Condition(s):			

FEVER:	No Concern ☐		**TRAUMA :**	No Concern ☐	
Temperature (if known): Feels hot ☐			Precipitating event?		
When did fever start?			Time occurred?		
Tylenol ☐ or Advil ☐ given?	**Y**	**N**	Bleeding?	**Y**	**N**
When? How much?			Bruising?	**Y**	**N**
Did it take the fever away?	**Y**	**N**	Swelling?	**Y**	**N**
Seizure activity?	**Y**	**N**	Movement?	**Y**	**N**
Hx of seizures?	**Y**	**N**	Weight Bearing?	**Y**	**N**
Immunization in last 24 hours?	**Y**	**N**	Pain? Intensity of Pain (1-10 Scale):	**Y**	**N**
On antibiotics or just finished? Reason:	**Y**	**N**	Location: Localized ☐ or Referred ☐		
RESPIRATORY :	No Concern ☐		**SKIN/MSK:**	No Concern ☐	
How is their breathing? Normal ☐ Fast ☐ Difficult ☐			Burn ☐ or Laceration ☐ Location:		
Cough?	**Y**	**N**	Rash? Location:	**Y**	**N**
Is it worsening?	**Y**	**N**	Known food related?	**Y**	**N**
Noisy Breathing?	**Y**	**N**	Known Medication related?	**Y**	**N**
Is it worsening?	**Y**	**N**	Itchy?	**Y**	**N**
Any blue colour around lips, hands or feet now?	**Y**	**N**	Colour Change?	**Y**	**N**
Any blue colour around lips, hands or feet before? How many times?	**Y**	**N**	Area warm to touch?	**Y**	**N**
Using belly muscles while trying to breath?	**Y**	**N**	Sensation changes?	**Y**	**N**
Head moving up & down when trying to breath?	**Y**	**N**	Changes to movement?	**Y**	**N**
Nostrils moving in & out when trying to breath?	**Y**	**N**	**GU:**	No Concern ☐	
Activity level:			Burning / Pain with voiding?	**Y**	**N**
Are they able to eat and drink as usual?	**Y**	**N**	Urgency?	**Y**	**N**
# wet diapers today? or # times voided today?			Odour?	**Y**	**N**
Foreign body?	**Y**	**N**	Fever?	**Y**	**N**
Ingested toxin?	**Y**	**N**	# wet diapers? # times voided?		
GI:	No Concern ☐		**NEURO :**	No Concern ☐	
Vomiting? # times in 24 hrs:	**Y**	**N**	Level of Consciousness: Alert ☐ Altered ☐		
Diarrhea? # times in 24 hrs:	**Y**	**N**	Stiff neck?	**Y**	**N**
Pain? Where:	**Y**	**N**	Headache?	**Y**	**N**
Eating / drinking? Usual for child ☐ Less ☐ More ☐			Vomiting? # of times today?	**Y**	**N**
# wet diapers today? or # times voided today?			Child seems floppy?	**Y**	**N**
Foreign body?	**Y**	**N**	Seizures?	**Y**	**N**
Ingested toxin?	**Y**	**N**	History of Seizures?	**Y**	**N**

***** ASSESSMENT CONTINUES ON BACK PAGE *****

Name of Patient:	**Age / DOB**:

Mental Health:					No Concern ☐
Current thoughts of self-harm/ suicide?	**Y**	**N**	Current thoughts of harming another person?	**Y**	**N**
Past thoughts of self-harm / suicide?	**Y**	**N**	Past thoughts of harming another person?	**Y**	**N**
Prior Suicide attempts?	**Y**	**N**	Recent trauma exposure?	**Y**	**N**
Substance use / abuse? Current ☐ Past ☐	**Y**	**N**	Victim of violence / abuse?	**Y**	**N**
School concerns?	**Y**	**N**	Any recent losses?	**Y**	**N**
Ever accessed mental health services?	**Y**	**N**	☐ Family services or ☐ law enforcement involvement?	**Y**	**N**

ASSESSMENT : (0-1hour) _____ Urgent (1-4 hours) _____ Non-urgent _____

Complete the next two sections if the patient is not being seen immediately at the health centre and advice is being provided

PRELIMINARY DIFFERENTIAL DIAGNOSES:

Intervention(s) and Advice Given:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Follow up Plan:

Caller advised to: Come to Clinic: Now ☐ next 4 HRS ☐ Time: _____ in AM ☐ Date / time:_____

(**Refer to *Pediatric and Adult Triage Policy* for list of all clients that must be assessed in clinic within 1-4 hours of the call)**

Additional details:

_____
_____
_____
_____
_____

Other Comments:_____
_____

CALLER'S RESPONSE TO PLAN:

☐ caller agreeable ☐ caller refused (provide additional details if refused)

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut Policy 07-030-00	**TITLE** **ADULT TELEPHONE TRIAGE FORM** **Age 12 years and older**

Name of Caller:	**Date**:	**Time**:	**Phone**:
Name of Patient:	**Gender:** M / F	**Age / DOB**:	
Relationship of caller to patient:		**Location of caller:**	
Chief Complaint:			

History of Presenting Illness:

Onset and Duration of the Event: (When did it start? How long has this condition lasted? What was pt doing when it started?)

Severity / Character: (How bothersome is this problem? Does it interfere with daily activities or keep pt up at night? Pt description of symptoms– use pain scale when appropriate)

Is it similar to a past problem? ☐ Y ☐ N If so, what was done at that time?

Location/Radiation: (Is the symptom (e.g. pain) located in a specific place or radiate? Has this changed over time?)

Treatment to Date: (Has pt tried any therapeutic maneuvers? Did it make it better or worse?)

Pace of illness: (Is the problem getting better, worse, or staying the same? How quickly or slowly has it been changing?)

Are there any associated symptoms? (Has the pt noticed other symptoms around the same time as the dominant complaint?)

What does the pt think the problem is and/or what he/she is worried it might be?

Why today? (When the cc that has been long standing -Is there something new/different today compared to previous days when present?)

Mental Health: No Concern ☐

Current thoughts of self-harm/ suicide?	**Y**	**N**	Current thoughts of harming another person?	**Y**	**N**
Past thoughts of self-harm / suicide?	**Y**	**N**	Past thoughts of harming another person?	**Y**	**N**
Prior Suicide attempts?	**Y**	**N**	Recent trauma exposure?	**Y**	**N**
Substance use / abuse? Current ☐ Past ☐	**Y**	**N**	Victim of violence / abuse?	**Y**	**N**
☐ School concerns? Or ☐ Job Loss?	**Y**	**N**	Any recent losses?	**Y**	**N**
Homelessness	**Y**	**N**	☐ Family services or ☐ law enforcement involvement?	**Y**	**N**
Ever access mental health services?	**Y**	**N**	Other:		

Current Medications:

Allergy status: ☐ NKDA ☐ Known (specify):

***** ASSESSMENT CONTINUES ON BACK PAGE *****

Name of Patient:	**Age / DOB**:

Relevant Past Medical / Surgical History:

LMP: ☐ N/A ☐ Date: ☐ Post menopausal ☐ Not known ☐ Pregnancy previously confirmed

The following clients are to be seen in the health centre immediately or within 4 hours of the call
(based on the urgency of the presenting symptoms from the telephone triage)

☐ Condition is determined to: ☐ Require resuscitation ☐ Be emergent ☐ Be urgent	☐ ≥ Age 65
☐ Complex medical condition(s)	☐ In RCMP Custody
☐ Pregnant	☐ ≤ Two (2) weeks postpartum
☐ Discharged in the last 48 hour from a hospital or care facility	☐ Had a surgical procedure under general anaesthetic within the previous ten (10) days
☐ Had an endoscopic procedure (gastroscopy or colonoscopy) within the previous three (3) days	☐ Multiple visits or multiple calls to the Health Centre in previous seventy-two (72) hours with the same presenting complaint(s)

Complete the next two sections if the patient is not being seen immediately at the health centre and advice is being provided

PRELIMINARY DIFFERENTIAL DIAGNOSES:

Intervention(s) and Advice Given:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Follow up Plan:

Caller advised to: Come to Clinic: Now ☐ next 4 HRS ☐ Time: _____ in AM ☐ Date / time:_____

Additional details:

_____
_____
_____
_____

Other Comments:_____
_____

CALLER'S RESPONSE TO PLAN:

☐ caller agreeable ☐ caller refused (provide additional details if refused)

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record