PATIENT DATA FORM FOR ED CHART

NEW PATIENT: ☐ INFOMATION UPDATE: ☐

Last Name:		First Name:		MD	Birthdate:
Sex:	Race:	Religion:		Marital Status:	
Social Security # :		Maiden Name:			
Patient Address:					Apt #:
City:	State:	Zip Code:	Primary Care Physician:		
Telephone #:	Cell Phone #:	E-mail Address:			Can we text or email you? ◯ Yes ◯ No
Employer's Name:	Employed: ◯ Yes ◯ No	Full-time: ◯	Part-time: ◯	Not Employed: ◯	

NEXT OF KIN:

Name:		Relationship:
Address:	Apt #:	Telephone #:
City:	State:	Zip Code:

EMERGENCY CONTACT: CHECK HERE IF SAME AS NEXT OF KIN: ☐

Name:		Relationship:
Address:	Apt #:	Telephone #:
City:	State:	Zip Code:

HOW DID YOU TRAVEL HERE TODAY? (CHECK ONE):

◯ Private Ambulance ◯ Police ◯ Family/Friend ◯ EMS Ambulance ◯ Correctional Services ◯ Self ◯ Other

ARE YOU HERE AS A RESULT OF AN ACCIDENT? IF YES, CHECK ONE:

◯ Auto Accident ◯ Work Related ◯ Other Accident

Date of Accident:	Time of Accident:	Type of Accident:

PRIMARY INSURANCE INFORMATION

Insurance Company:	Policy#:
Address:	Phone #:

SECONDARY INSURANCE INFORMATION

Insurance Company:	Policy#:
Address:	Phone #:

FOR PEDS PATIENT ONLY:

Parents Last Name:	Parents First Name:			Parents DOB:
Employer's Name:	Telephone #:			
Employer's Address:	City	State:	Zip Code:	

INSURANCE POLICY HOLDER FOR CHILD:

Name:	Relationship:	DOB:

FORMULARIO DE DATOS DEL PACIENTE

Paciente Nuevo: ☐ Nueva Informacion: ☐

Apellido:		Nombre:	SN:	Fecha De Nacimiento:
Sexo:	Raza:	Religion:	Estado Civil:	
Numero De Seguro Social:		Nombre De Soltera/o:		
Direccion:			Numero De Apt:	
Cuidad:	Estado:	Zona Postal:	Doctor Primario:	
Telefono (casa):	Numero De Celular:	Correo Electronico:	Le podemos mandar un mensaje de texto o correo Electronico? ◯ Si ◯ No	
Nombre de Empleador:	Esta Empleado? ◯ Si ◯ No	Tiempo Completo: ◯	Medio Tiempo: ◯	Desempleado: ◯

FAMILIAR MAS CERCANO:

Nombre:		Relacion:
Direccion:	Numero De Apt:	Numero de Telefono:
Cuidad:	Estado:	Zona Postal:

CONTACTO DE EMERGENCIA: MARQUE AQUI SI ES IGUAL QUE SU FAMILIAR MAS CERCANO ☐

Nombre:		Relacion:
Direccion:	Numero De Apt:	Numero de Telefono:
Cuidad:	Estado:	Zona Postal:

COMO LLEGO AQUI HOY? (MARQUE UNO)

◯ Ambulacia Privada ◯ Policia ◯ Familiar/Amigo ◯ Ambulancia Del Servicio De Emergencia ◯ Servicio Correccionales
◯ Por Si Mismo ◯ Otro Modo

ESTA USTED AQUI COMO RESULTADO DE UN ACCIENTE? SI SU RESPUESTA ES SI MARQUE UNO:

◯ Accidente Automotriz ◯ Relacionado al Trabajo ◯ Otro tipo de Acciente

Fecha De Accidente:	Hora De Accidente:	Tipo De Accidente:

INFORMACIO SOBRE SU SEGURO MEDICO (PRIMARIO)

Nombre De Seguro Medico:	Numero De Poliza:
Direccion:	Numero De Telefono:

INFORMACIO SOBRE SU SEGURO MEDICO (SECUNDARIO)

Nombre De Seguro Medico:	Numero De Poliza:
Direccion:	Numero De Telefono:

PARA PACIENTES DE PEDEATRIA SOLAMENTE:

Apedillo De el Padre/Madre:	Nombre de el Padre/Madre:		Fecha De Nacimieto:
Nombre De Empleador:	Telefono:		
Direccion De Empleador:	Cuidad:	Estado:	Zona Potal:

POSEEDOR DE SEGURO MEDICO DE SU NINA/O:

Nombre:	Relacion:	Fecha De Naciento:

Mount Sinai Hospital

THE MOUNT SINAI HOSPITAL, NEW YORK

PEDIATRIC ED NURSING TRIAGE AND ASSESMENT FORM

☐ PULL PINK ☐ RECALLED ☐ LAST ED VISIT: _____
☐ ACCIDENT

DATE
NAME
UNIT - SEX/DOB
SERIAL - / LOCATION
PHYSICIAN/ SERVICE

DATE:	TIME: ☐ AM ☐ PM
Presenting Complaint:	
Category: ☐ CRITICAL ☐ ACUTE ☐ SUBACUTE ☐ URGENT ☐ PSYCH	
SIGNATURE: RN	

NAME:

SEX: ☐ M ☐ F	DOB:	AGE:

Date: Time:	MODE OF ARRIVAL: ☐ EMS ☐ WALK ☐ CARRIAGE/STROLLER ☐ CARRIED ☐ PVT. AMB. ☐ W/C ☐ STRETCHER
ACCOMPANIED BY:	Primary Provider/Clinic:

NURSING ASSESSMENT

	T: O / R / T
	P:
	R:
	BP:
	Weight: KG
	LMP:

Past Medical History: ☐ Denies ☐ Asthma ☐ Other

Current Medications: ☐ None

Allergies: ☐ None Known

IMMUNIZATIONS

☐ BY CARD ☐ BY HISTORY
☐ UP TO DATE LAST TETANUS: _____
☐ DELAYED*
☐ UNKNOWN*

*☐ REFERRED TO PEDS CLINIC
*☐ REFERRED TO ADOLESCENT HEALTH
*☐ REFERRED TO: _____

☐ ISOLATED ☐ MASK

ORIENTATION

☐ ALERT, ORIENTED
☐ CONFUSED
☐ OTHER _____

BEHAVIOR

☐ NORMAL, ACTIVE
☐ LETHARGIC
☐ IRRITABLE
☐ RESTLESS

RESPIRATORY

☐ N/A
☐ CLEAR
☐ WHEEZING
☐ RETRACTIONS
☐ STRIDOR
☐ O_2 SAT: _____

HYDRATION STATUS

☐ N/A
☐ MOIST MUCUS MEMBRANES
☐ TEARS
☐ TOLERATING P.O. FLUIDS
LAST VOID: _____
☐ BAG APPLIED
☐ CLEAN CATCH REQUESTED

SKIN COLOR

☐ NORMAL
☐ WARM
☐ DRY
☐ COOL
☐ DIAPHORETIC
☐ PALE
☐ FLUSHED
☐ CYANOTIC
☐ RASH

MUSCULOSKELETAL

☐ N/A
☐ DEFORMITY
☐ SWELLING
☐ ECCHYMOSIS
☐ ABRASIONS
☐ LACERATION
☐ BURN
☐ WOUND CARE
☐ BITE _____
☐ PUNCTURE

☐ Patient Watch Date: Time:	Screening Nurse Signature RN

DATE TIME	PROGRESS NOTES
	Signature

Mount Sinai Hospital

THE MOUNT SINAI HOSPITAL, NEW YORK
AER TRIAGE & ASSESSMENT

ADULT ED – TRIAGE

☐ PULL PINK ☐ RECALLED ☐ LAST ED VISIT: _____
☐ ACCIDENT

DATE
NAME
UNIT - SEX/DOB
SERIAL - / LOCATION
PHYSICIAN/ SERVICE

DATE: | TIME: ☐ AM ☐ PM

Primary Provider/Clinic:

Presenting Complaint

NAME:

➔ TRIAGE SIGNATURE: RN | SEX: ☐ M ☐ F | DOB: | AGE:

MODE OF ARRIVAL: ☐ AMBULANCE ☐ AMBULATORY ☐ W/C ☐ OTHER: _____ ACCOMPANIED BY: _____

PRE-HOSPITAL CARE: ☐ EMS ☐ PVT. AMB. ☐ OTHER: _____ ☐ NONE | EMS VITALS BP: P: R: GCS:

T_X: ☐ IV: AMT ABSORBED: ☐ DRSG ☐ C-COLLAR ☐ C-SPINE IMMOBILIZATION ☐ SPLINT ☐ SLING ☐ OTHER: _____

TRIAGED TO: ☐ CRITICAL ☐ ACUTE ☐ ZONE A ☐ URGENT ☐ PSYCH
ENDORSED TO: ☐ N/A

CURRENT MEDICATIONS: ☐ NONE

MEDICAL HISTORY ☐ NONE

☐ ARTHRITIS	☐ HEMOPHILIA	☐ PNEUMONIA	☐ SEIZURE
☐ ASTHMA	☐ HEPATITIS	☐ PID	☐ SICKLE CELL
☐ CANCER	☐ HIV+	☐ PUD	☐ SUBSTANCE ABUSE
☐ CARDIAC	☐ HTN	☐ PVD	
☐ COPD	☐ LIVER	☐ RENAL	☐ TB
☐ CVA	☐ LIVER TRANSPLANT	☐ PD	☐ OTHER
☐ DIABETES		☐ HEMO	
☐ DOMESTIC VIOLENCE	☐ COVID	☐ LAST Rx	

OTHER: _____

ALLERGIES:

LMP: NORMAL: ☐ Y ☐ N Gravida Para Ab

LAST TETANUS: ☐ N/A

NURSING ASSESSMENT

TIME: ☐ Interpreter required ☐ Victim of Domestic Violence

RESPIRATORY	L	R
☐ N/A		
CLEAR	☐	☐
CRACKLES	☐	☐
WHEEZING	☐	☐
STRIDOR	☐	☐
DIMINISHED	☐	☐
ABSENT	☐	☐
LABORED	YES	NO

MUSCULOSKELETAL
☐ NIA
☐ DEFORMITY
☐ SWELLING
☐ ABRASIONS
☐ ECCHYMOSIS
☐ LACERATION
☐ BURN ☐ 1° ☐ 2° ☐ 3°
☐ WOUND CARE
BITE _____
☐ PUNCTURE

SKIN/COLOR
☐ WARM
☐ DRY
☐ COOL
☐ DIAPHORETIC
☐ RASH ISOLATION Y or N
☐ GOOD
☐ PALE
☐ FLUSHED
☐ JAUNDICED
☐ CYANOTIC
☐ SKIN BREAKDOWN

ORIENTATION
☐ PERSON
☐ PLACE
☐ TIME / DATE
☐ CONFUSED
☐ LETHARGIC
☐ OTHER

REQUESTS FROM TRIAGE
☐ EKG
☐ MASK APPLIED
☐ RESP. ISOLATION
☐ PATIENT WATCH DATE/TIME

TEMP: O / R / T

	SITTING	STANDING	LAYING
PULSE			
RESP.			
BP:			

PULSE OX % ON

FS BLOOD GLUCOSE:

SIGNATURE: RN

SURVEILLANCE

TIME: ☐ AM ☐ PM

NEW TRIAGE CATEGORY ☐ CRIT ☐ ACUTE ☐ SUBAC ☐ URG

VITALS: T P R BP FS

SURVEILLANCE:
- Have you, or a member of your household, been diagnosed with **Covid-19** in the past 14 days? YES NO NA
- Recent travel or close contact with a sick traveler in the last 21 days? YES NO NA

SIGNATURE: RN

SUICIDE RISK ASSESSMENT:

SIGNATURE: RN

FORM O-201 Rev. 11/21_b White - Medical Records Pink - ED Gold - Clinic Yellow - Billing

THE MOUNT SINAI HOSPITAL
EMERGENCY DEPT CHART

Disaster Victim # _____ Field Tag # _____

Patient Name: _____

Date: _____ PMD: _____

INITIAL TIME SEEN _____ **INITIAL ED PROVIDER** _____ (PRINT)

DATE

NAME

UNIT NO. SEX/DOB

SERIAL NO LOCATION

PHYSICIAN/ SERVICE

ALLERGIES:

LAST TETANUS _____ (YEARS AGO)

LMP:

SURG HX:

SOC HX: CIGS
ETOH
COCAINE
IVDU

MEDICATIONS:

☐ SEE TRIAGE SHEET

MD/NP ASSESSMENT O_2 sat T P R BP

☐ see _____ sheet

REVIEW OF SYSTEMS

Describe all abnormal or pertinent findings ☐ N/A

SYSTEM	Specify Abnormal	Normal
Eyes		
E.N.T.		
Cardiovascular		
Respiratory		
GI		
GU		
Musculoskeletal		
Skin		
Neuro		
Psychiatric		
Endocrine		
Blood/Lymph		
Allergic/Immune		

SIGN #1 _____ MD/NP DICT CODE _____ ENDORSED TO DR. _____ AT _____

SIGN #2 _____ MD/NP DICT CODE _____ DISCUSSED WITH DR. _____

ATTENDING/PMD NOTE

DATE _____ TIME _____

☐ I have seen and evaluated this patient. I have reviewed the ☐ Residents / ☐ PA documentation and findings and discussed the plan of care.

DICT

THE MOUNT SINAI HOSPITAL, NEW YORK
EMERGENCY DEPT CHART

DATE

NAME

UNIT NO.
SEX/DOB

SERIAL NO
LOCATION

PHYSICIAN/
SERVICE

LABORATORY RESULTS

STREP _____ BHCG _____

U/A: SG ___ PROT _____ GLU _____ KET _____ BILI _____ BLOOD ____

LEUK ____ NIT _____ RBC _____ WBC _____ BACT ____ EPITH ____

ABG (FIO_2)	pH	pCO_2	pO_2	% Sat	A-a gradient

#1 Hb / Wbc / Plt / Hct

#2 Hb / Wbc / Plt / Hct

PT _____
PTT _____

EKG #1

EKG #2

DIFF:
#1 Na / Cl / BUN / Glu / K / CO_2 / Cl

DIFF:
#1 Na / Cl / BUN / Glu / K / CO_2 / Cl

☐ I have reviewed the Resident / PA interpretation of the ECG and agree.

TIME #1	#2	#3
CPK		
MB		

CONSULTS/PMD

(SEE SHEETS) TIME

SERVICE NAME	PHONE/BEEPER	CALLED	RESPONDED	SEEN

DIAGNOSTIC STUDIES/OTHER LABS

PROCEDURE

☐ CONSENT SIGNED ☐ STERILE PREP ☐ TOLERATED WELL

CONTINUATION / PLAN

CULTURES IF SENT: Throat Urine Blood Stool Wound CSF Cx Other

Date: Time:

CONDITION ON DISCHARGE

☐ Improved ☐ Unchanged

TYPE OF DISCHARGE:

☐ Treated & Released
☐ AMA
☐ Transferred to: _____
☐ Return to Nursing Home
Time _____ am / pm _____
☐ Expired

☐ CHART COMPLETED
☐ CHART PROCESSED
☐ DISCHARGED BY NURSE
☐ DISCHARGED BY REGISTRAR

DIAGNOSIS

1. 2.

3. 4.

Signature _____, MD/NP Dict Code

Print Name _____

MS0215 Rev. 7/06

MEDICAL RECORDS COPY

101680

THE MOUNT SINAI HOSPITAL
NEW YORK, NEW YORK

CONSULTATION REPORT

REQUESTED BY: _____ M.D.
SIGNATURE OF PHYSICIAN & SERVICE

DICTATION NO: _____

TO: _____ M.D.
CONSULTING PHYSICIAN OR SERVICE

DATE

NAME

UNIT NO.: SEX/D.O.B

SERIAL NO LOCATION

PHYSICIAN SERVICE

DATE

REASON FOR CONSULTATION:

CONSULTANT'S FINDINGS: (HISTORY AND PHYSICAL)

OPINION AND RECOMMENDATIONS:

DATE _____ TIME _____ _____ M.D. _____
SIGNATURE OF CONSULTANT TITLE OF CONSULTANT

D-I-A-20
Rev. 7/97

PLEASE DO NOT WRITE IN THIS SPACE-WRITE ON THIS SIDE OF PAPER ONLY

CHART COPY

STAPLES PRINT SOLUTIONS (212) 462-7586

300482

THE MOUNT SINAI HOSPITAL, NEW YORK

EMERGENCY DEPARTMENT ASSESSMENT RECORD CONTINUATION SHEET

NAME:

#:

DATE:

Page # ____________

Date/Time	Vital Signs:	Progress Notes:
		☐ See next page

EMERGENCY DEPARTMENT CUSTOMIZED LAB REQUISITION

Mount Sinai

(212) 241-5227

NAME

WHEN ORDERING TESTS FOR MEDICARE AND MEDICAID PATIENTS, PLEASE ORDER ONLY THOSE TESTS WHICH ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT, RATHER THAN FOR SCREENING PURPOSES.

Requesting Physician Name:

PHYSICIAN'S SIGNATURE

NAME

UNIT NO.

SEX / DOB

PHYSICIAN

MANDATORY FOR MEDICAID PATIENTS

Physician's Dict. Code:

Request Date: Time:

Collection Date: Time:

Provisional Diagnosis:

PANEL/PROFILES

3001	ER ARTERIAL PANEL: ABG, GLUC, NA, K, CL, BUN, LAC, HCRIT S	330	BLOOD GAS – ART S		
3002	ER VENOUS PANEL: GLUC, NA, K, CL, O2, BUN, CREAT, HCRIT S	331	BLOOD GAS – VEN S		
203	CBC, PLT & DIFF	804	AMA – ASM – ANA		
9117	CHEM 7: NA, K, CL, CO2, GLU, BUN, CREAT	1041	ER DRUG SCREEN – URINE		
1319	LIVER TRANSPLANT MON.	3003	ICU ARTERIAL PANEL: ABG, GLUC, NA, K, CL, CA, LAC, HCRIT S		
1314	PAT MONITORING	3004	ICU VENOUS PANEL: VBG, GLUC, NA, K, CL, CA, LAC, HCRIT S		
1413	CYCLOSPORIN (TROUGH LEVEL)	749	THYROID FUNC: TSH		
1147	CARDIAC: CK – MB	1155	LIPID PANEL		
1801	TROPONIN				

MISCELLANEOUS LISTING

1104	ACETONE	4272	HEPATITIS B CORE AB
1105	ALBUMIN	4277	HEPATITIS C VIRUS AB
1134	ALKALINE PHOSPHATASE	703	HEMOGLOBIN A1C L
1143	ALT (SGPT)	855	IMMUNOELECTRO
1107	AMMONIA	1146	LACTATE GY 1
1109	AMYLASE	1130	LDH
1142	AST (SGOT)	1783	LIPASE
379	BHCG (QUAL) SERUM	1131	MAGNESIUM
323	BHCG (QUANT) SERUM	315	OSMOLALITY
378	BHCG – URINE	747	PROLACTIN
733	B12 / FOLATE L	1443	PROTEIN FLUID
1112	BILIRUBIN, TOTAL		SOURCE_____
877	C-REACTIVE PROTEIN	1140	PROTEIN, T
1116	CALCIUM	345	PT B
202	CBC, PLT L	346	PTT B
3332	CARBOXY HEMA, ARTERIAL	380	Q-STREP
3342	CARBOXY HEMA, VENOUS	206	RETIC COUNT L
724	CORTISOL	880	SERUM PROTEIN ELEC.
1120	CPK	420	SYPHILIS RPR SCREEN
1121	CREATININE	221	URINALYSIS
2528	D-DIMER B	1270	VALPROIC ACID
1111	DIRECT BILI		
210	ESR B		
1400	FE/TIBC		
275	FLUID CELL Count & Diff.		
1442	GLUCOSE FLUID		
	SOURCE_____		
8069	HEPTOGLOBIN R		
4273	HEPATITIS A AB (IGM)		
4261	HEPATITIS B SURFACE AB		
4271	HEPATITIS B SURFACE AG		

TITERS

4330	ASLO
4622	CMV
432	CRYPTO, AG SERUM
4633	EBV AB
4624	HERPES AB
4550	LYME – SERUM
4621	TOXO, AB
4612	VARICELLA – ZOSTER

CSF TESTS

SPECIALTY TUBE #:

TUBE #_____CELL COUNT

TUBE #_____C & S, GRAM STAIN AND

(CIRCLE)

CIE AFB IndInk CRYPTO

HERPES: LYME VIRAL

TUBE #_____CHEM: PROT GLU_____

TUBE #_____(CIRCLE)

CELLCOUNT VDRL

ADDITIONAL TESTS

DRUG ASSAYS

1149	ACETAMINOPHEN	1163	PHENYTOIN
1178	ALCOHOL	1795	PROGRAF
1193	CARBAMAZEPHINE	1141	SALICYLATES
1194	DIGOXIN	1101	THEOPHYLLINE
1103	LITHIUM	1203	TRICYCLICS (QUAL)
1164	PHENOBARB	1270	VALPROIC ACID

MICROBIOLOGY

4305	B STREP, THROAT CULTURE
404	BLOOD CULTURE
499	C & s OTHER _____
497	EYE CULTURE
P994	CHLAMYDIA / GC PROBE
415	FUNGAL CULTURE
	SOURCE:_____
463	HERPES VIRUS CULTURE
480	AFB CULTURE & SMEAR
	SOURCE:_____
461	RSV CULTURE
470	SPUTUM CULTURE
400	URINE CULTURE
440	WOUND CULTURE
460	VIRAL CULTURE
	SOURCE:_____
4646	C. DIFFICULE TOXIN STOOL
450	CULTURE STOOL
454	OVA AND PARASITE STOOL

All blood tests require a speckled top tube except as noted. S = Syringe; R = Red; B = Blue; GN = Green; L=Lavender; GY = Grey; I = On Ice;

All Stat lab chemistries require a syringe

THE MOUNT SINAI HOSPITAL
NEW YORK, NEW YORK

REQUEST FOR RADIOLOGY CONSULTATION

DATE:

NAME:

UNIT NO/
SEX/DOB:

SERIAL NO/
LOCATION:

PHYSICIAN/
SERVICE:

CLINIC NAME:	CLINIC #:	RETURN DATE:

EXAM(S): (indicate if contrast is desired)

MANDATORY: CLINICAL DIAGNOSIS & OTHER PERTINENT INFORMATION

FOR IV CONTRAST STUDY:

	DATE
BUN:	
CREAT:	

ALLERGIES: YES ☐ NO ☐ SPECIFY:

PREGNANT? YES ☐ NO ☐ LMP:

IV CONTRAST CONTRAINDICATED: YES ☐ NO ☐

STAT ☐ PORTABLE ☐ ISOLATION ☐

PT. ABLE TO STAND YES ☐ NO ☐ PT. ABLE TO SIT YES ☐ NO ☐

TRANSPORT ☐ W/C ☐ STR ☐ IV POLE ☐ OXYGEN

PHYSICIAN OR NURSE MUST ACCOMPANY PATIENT RECEIVING BLOOD OR OXYGEN

RADIOLOGIST COMMENTS:

MANDATORY:

REQUESTING MD'S SIGNATURE	BEEPER #:	DICT. CODE:
REQUESTING MD (PLEASE PRINT)	PHONE #:	DATE:

D-5-A-20 Rev. (5/99)

THE MOUNT SINAI HOSPITAL
NEW YORK, NEW YORK
EMERGENCY DEPARTMENT ORDER SHEET
USE BALLPOINT PEN ONLY

Medication Orders MUST include drug, dose, route, frequency and time, date, and signature.

DATE

NAME

UNIT # SERVICE

SERIAL # / LOCATION

PHYSICIAN / SERVICE

ALLERGIES:

NAME: DOB

ORDERS

Use Full Block for Nebulizer Orders.

DATE	TIME	PRESCRIBER'S SIGNATURE	DATE	TIME	RN SIGNATURE

DATE	TIME	PRESCRIBER'S SIGNATURE	DATE	TIME	RN SIGNATURE

DATE	TIME	PRESCRIBER'S SIGNATURE	DATE	TIME	RN SIGNATURE

DATE	TIME	DATE	TIME	DATE	TIME	DATE	TIME	DATE	TIME	DATE	TIME

NURSE'S INITIALS & SIGNATURE							

THE MOUNT SINAI HOSPITAL — NEW YORK, NY 10029
ORDER SHEET

GENERAL GUIDELINES

1. ENTER ALL ORDERS OR PROCEDURES
2. URGENT ORDERS MUST BE CALLED TO THE ATTENTION OF THE NURSE.
3. TO CHANGE OR DISCONTINUE AN ORDER A COMPLETE NEW ENTRY MUST BE MADE.
4. DATE, TIME PRESCRIBER'S SIGNATURE AND DICTATION NUMBER MUST FOLLOW EACH SET OF ORDERS.

DATE	TIME	IN ACCORDANCE WITH THE HOSPITAL FORMULARY SYSTEM CURRENTLY STOCKED DRUGS WILL BE DISPENSED ORDER	RN/ LPN √	

YELLOW COPY MUST SHOW THROUGH HOLE

NUMBER MUST APPEAR BEFORE DOCTOR WRITES ORDERS

NO. OF SHEETS REMAINING

2

FLOOR COPY

KEEP UNTIL

MEDICATION RECEIVED

ALLERGIES: (Must be completed)

THE MOUNT SINAI HOSPITAL
NEW YORK

INPATIENT DRUG REQUISITION

EXT. 47714 OR 5

Please write legibly and in ink.

Addressograph imprint must be clear.

Circle or write in dosage form.

DATE

NAME

UNIT NO./ SEX/DOB

SERIAL NO./ LOCATION

PHYSICIAN/ SERVICE

PHARMACY

DRUG

POTENCY/DOSE

QUANTITY ORDERED

ROUTE OF ADMINISTRATION			DOSAGE FORM		
I.V.	ORAL	OPHTH	TAB	DROP	POWDER
I.M.	RECTAL	OTIC	CAP	CREAM	SUPPOS
SUB. Q.	VAGINAL	NASAL	LIQUID	OINTMENT	
		TOPICAL			

DIRECTIONS FOR USE

INTERN
RESIDENT
ATTENDING

FILLED OUT BY

M.D.
R.N.

DO NOT WRITE IN THIS SPACE

B-2-C-1B (REV. 8/99)

FLOOR COPY

THE MOUNT SINAI HOSPITAL – NEW YORK
REQUEST FOR BLOOD COMPONENT

DATE OF REQUEST / /	RECEIVED BY		TIME
REQUESTED BY DR	(SIGNATURE)	DICTATION NO	
DISPENSED BY	DATE / /		TIME

CHECK BOX ☐ NEXT TO COMPONENT REQUEST AND INDICATE NO. UNITS – IF PATIENT REQUIRES UNLISTED PRODUCT. INDICATE PRODUCT AND UNITS UNDER "OTHER"

CODE	PRODUCT	ONE UNIT EQUALS	NO. UNITS
143004	☐ PACKED RED CELLS	200 ml	
143002	☐ WHOLE BLOOD	450 ml	
143020	☐ FROZEN RED CELLS	200 ml	
143154	☐ WASHED RED CELLS	200 ml	
143288	☐ FILTERED RED CELLS *	200 ml	
143006	☐ PLATELETS, POOLED	UNIT	
143290	☐ PLATELET, SING. DONOR	UNIT	
143282	☐ PLATELETS, HLA MATCH *	UNIT	
143016	☐ FROZEN PLASMA (Fresh)	250 ml	
143080	☐ RHOGAM	VIAL	
143256	☐ IRRADIATION *		
143010	☐ CRYOPRECIPITATE	UNIT	
143082	☐ LEUKOCYTES *	UNIT	
143248	☐ STIMATE (DDAVP)	VIAL	
143214	☐ FEIBA	UNIT	
	☐ FACTOR VIII	UNIT	
	☐ FACTOR IX	UNIT	
	☐ OTHER		

DATE	
NAME	
UNIT NO./ SEX/DOB	
SERIAL NO./ LOCATION	
PHYSICIAN/ SERVICE	

TO BE COMPLETED BY BLOOD BANK

PATIENT'S BLOOD TYPE _____

IDENTIFICATION # _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

* Subject to Blood Bank approval

REASON FOR REQUEST (Must be completed or request will be delayed!!)

DIAGNOSIS:

HEMOGLOBIN _____ GM/dL HEMATOCRIT _____ %

PLATELET _____ uL WBC _____ uL

PT I_____ SEC/ _____ SEC | PTT _____ SEC/ _____ SEC

FIBRINOGEN _____ MG/dL

BLEEDING TIME _____ MIN

FACTOR _____ _____ %

SURGICAL/INVASIVE PROCEDURE: ☐ YES

Anticipated/Estimated Blood Loss _____ ML

BLEEDING: ☐ YES

IMMUNOSUPPRESION: ☐ YES

Rh INCOMPATIBILITY: ☐ YES

TRANSFUSION HISTORY ☐ PREGNANCY ☐

OTHER REASON: _____

FORM # ZNYMSD8A4 (REV. 12/20)

Mount Sinai

PAGE ___OF___

DATE

NAME

UNIT NO.
SEX/DOB

SERIAL NO.
LOCATION

PHYSI-CIAN SERVICE

RECORD OF ADMINISTRATION OF PATIENT CONTROLLED ANALGESIA (PCA), EPIDURAL, NERVE BLOCK AND DOCUMENTATION OF WASTE FOR PCA, EPIDURAL, NERVE BLOCK AND CONTINUOUS INFUSION OF CONTROLLED SUBSTANCES AND ANALGESICS

MEDICATION ☐IV PCA ☐SubQ PCA ☐CONTINUOUS

- ☐ HYDROmorphone 1 mg/mL
- ☐ FENTANYL 25 mcg/mL
- ☐ MIDAZOLAM 1 mg/mL
- ☐ MORPHINE SULFATE 1 mg/mL
- ☐ HYDROmorphone 0.5 mg/mL PEDIATRIC
- ☐ OTHER_____

EPIDURAL

- ☐ FENTANYL 5 mcg/mL + BUPIVACAINE 0.1% CASSETTE
- ☐ BUPIVACAINE 0.1% CASSETTE

PAIN SERVICE ONLY

- ☐ FENTANYL_____+ BUPIVACAINE_____ EPIDURAL
- ☐ _____+ BUPIVACAINE_____ EPIDURAL
- ☐ OTHER_____ EPIDURAL
- ☐ BUPIVACAINE 0.1% PERIPHERAL NERVE CATHETER
- ☐ BUPIVACAINE_____PERIPHERAL NERVE CATHETER

PUMP SETTINGS							
DATE	TIME	CONTINUOUS RATE ☐MG ☐MCG ☐mL	PCA DOSE ☐MG ☐MCG ☐mL	PCA DOSE LOCKOUT (MIN)	MAX PCA DOSES/HOUR	HOURLY DELIVERY LIMIT	SIGNATURE/ TITLE

RECORD AT INITIATION/ DISCONTINUATION OF THERAPY, CHANGE OF SHIFT AND WHEN PATIENT IS TRANSFERRED

DATE	TIME	PATIENT LOCATION	CLINICIAN BOLUS ☐MG ☐MCG ☐mL	VOLUME IN BAG (mL)	VOLUME INFUSED (mL)	SIGNATURE/ TITLE
				mL		
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	
				mL	mL	

RECORD OF WASTE – NURSING ONLY					
DATE	TIME	PATIENT LOCATION	VOLUME DISCARDED	SIGNATURE/ TITLE	SIGNATURE/ TITLE
			mL		

RECORD OF RETURN TO PHARMACY – ANESTHESIA ONLY					
DATE	TIME	PATIENT LOCATION	VOLUME RETURNED	SIGNATURE/ TITLE	SIGNATURE/ TITLE
			mL		

The Mount Sinai Hospital, New York
Emergency Department

DATE

NAME

UNIT=
SEX/DOB

SERIAL =/
LOCATION

PHYSICIAN
SERVICE

PATIENT DISCHARGE INSTRUCTIONS

NAME: _____

MR #: _____

This form provides you with information about the care you received in our Emergency Department and information about caring for yourself at home. Please bring it with you should you need additional treatment.

You were seen by _____ on _____
Name of Provider date

Discharge Diagnosis _____ Instruction sheet(s) given: _____

Diet Recommendation ☐ regular ☐ other: _____

Activity as tolerated. You may return to work/school in _____ days.

MEDICATION PRESCRIBED:

Name	Dose	Duration	Purpose

ADDITIONAL INSTRUCTIONS _____

RETURN TO THE EMERGENCY DEPARTMENT IMMEDIATELY IF SYMPTOMS WORSEN, NEW SYMPTOMS OCCUR OR

FOLLOW-UP CARE:

☐ Own physician in _____days _____weeks.

Please stop at Discharge Desk to receive appointment before leaving.

☐ _____ Clinic in _____ days _____ weeks.

☐ _____ Clinic in _____ days _____ weeks.

☐ Please call the next working day (Monday-Friday 8AM-4PM) for appointment to

_____Clinic. (212) 241- _____ in _____ weeks.

☐ Please call for lab results in _____ days. Pediatrics: (7AM - 1PM) (212) 241-7151

Adult: (10AM - 8PM) (212) 241-1815.

☐ Return to Emergency Department in _____ days for _____.

☐ Workman's Compensation, please call (718) 802-6600 for referral.

☐ Victim of crime, please call (212) 241-5461 for counselling and non-emergency assistance.

I have received and understand the instructions.

_____
Patient (or Parent) Signature

Instructions given by _____ RN _____ MD

Date _____ Time _____ Dict code _____