PATIENT DATA FORM FOR ED CHART

				First Name	2;			MD	Birtho	late:
Sex:	Race:			Religion:		· · · · · · · · · · · · · · · · · · ·		Marital St	atus:	
Social Security #	# :			- 1	Maide	n Name:		<u></u>		
Patient Address:		1								Apt #:
City:	St	iate:	Zip C	Zip Code: Primary Care Phy			ury Care Physic	ian:		
Telcphone #:		Cell Phone	·#:	***	E-mai	l Address	5		Can we text or email you	
Employer's Nam	1e:	1		Employed:	s C) No	Full-time:	Part-ti	Not Employed:	
Yame:	·			<u>N</u>	(EXT 0)	F KIN:		Relationshi	n•	1
	38 20									
Address:	9	± 1			Apt #: Telephone #:				ř:	
City:			State:				10	Zip Code;		
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Name:			4-11-7	11				Relationshi	p:	
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FORMULARIO DE DATOS DEL PACIENTE

			Di esti	'aciente Nuevo):	Nueva Informacion:		
Apellido:		Nombre:		141	SN; Fech	a De Nacimiento:		
exo:	Raza:	Religion:		Est	ado Civil:			
lumero De Seguro S	Social:		Nombre De So	ltera/o:		ge -1 mag		
Direccion:						Numero De Apt:		
uidadı	Estado:	Zona Postal:	Doctor Pr	imario:	le Pérel.			
clefouo (casa):		Numero De Celular:		Correo Electr	onico:	Le podemos mandar un mensaje de texto o correo Electronico?		
Nombre de Emplead	or:	Esta Emplo	eado?	Tiempo Compl	eto: Medio	Tiempo: Desempleado:		
	1		JAR MAS C	ERCANO:		.500		
(ombre:					Relacion:			
direction:			Nu	mero De Apt:	Numero de	Telefono:		
Cuidad:		Estado:			Zona Posta	d:		
CONTA	CTO DE EMERGI	ENCIA: MARQUE AQ	UI SI ES IGI	JAL QUE S	U FAMILI	AR MAS CERCANO		
ombre:	1		Š.	0 2 7720	Relacion			
ireccion:	4		Nu	mero De Apt:	Numero de	e Telefono:		
uidad:	II.	Estado:			Zona Post	al;		
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ESTA I	JSTED AQUI COM	IO RESULTADO DE UN	ACCIENTE	? <u>SI</u>	SU RESPU	ESTA ES SI MARQUE UNO:		
Accidente Au	tomotriz Rela	cionado al Trabajo 🔘 0	tro tipo de Acci	ente				
Secha De Accidente		Hora De Accidente:	Т	ipo De Accider	ite;			
		INFORMACIO SOBRE	SU SEGUR	MEDICO	<u>(0)</u>			
lombre De Seguro	Medico:			r	Tumero De Po	liza:		
Direction:				ľ	Numero De Telefono:			
		INFORMACIO SOBRE	E SU SEGURO MEDICO (SECU			ARIO)		
Nombre De Seguro	Medico:			Г	Numero De Poliza:			
Direction:				7	Numero De Te	lefono:		
1		PARA PACIENTES DE	PEDEATR	IA SOLAM	ENTE:			
Apedillo De el Padr	e/Madre:	Nombre de el Pa	adre/Madre:			Fecha De Nacimieto:		
lombre De Emplea	dor:		Telefono	1	E II			
Direccion De Emple	eador:		Cui	dad:	Estado:	Zona Potal:		
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Nombre:	7	Relacion:			Ta Al	Fecha De Naciento:		

Date	NAME		AND ASS	ESMENT FORM								
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SEX: M F DOB: AGE:	SEGNATURE: RN	Category: CR				NAME:						
CARRIED	CARRIED	SIGNATURE:			RN	SEX:	□М	□F	DOB:		AGE:	1
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Signature	Cinnatura							IMPOTI-				

Mount	THE MOUNT SIN	IAI HOSPITAL, NEW ISSESSMENT		PULL PINK ACCIDENT	RECALLED	□ LAST EI	D VISIT:	
Hospital	ADULT EI	O - TRIAGE						DATE -
DATE:	TIME:	□ AN	п□РМ					NAME
Primary Provider/	Clinic:	- it.						UNIT - SEX/DOI
Presenting Comp	aint				L			SERIAL - LOGATIO
							e e	PHYSICI/ SERVICE
			NAM	ИE:				,
→ TRIAGE	SIGNATURE:		RN SEX	: □M □F	DOB:		AGI	E;
MODE OF ARRIVAL:	□ AMBULANCE □ A	MBULATORY DW/	C OTHER:		ACCC	MPANIED E	BY:	
PRE-HOSPITAL CAR	E: DEMS DPVT. AN	//B. □ OTHER:		NONE EMS V	ITALS BP:	P:	R:	GCS:
	MT ABSORBED:	□ DRSG □ C-COLL	AR C-SPINE	IMMOBILIZATIO	N SPLINT	□ \$LING [OTHER:	
ENDORSED TO: CURRENT MEDICA	□ N/A FIONS:		NONE	☐ ASTHMA ☐ CANCER ☐ CARDIAC ☐ COPD ☐ CVA ☐ DIABETES ☐ DOMESTIC VIOLENCE OTHER:	☐ HEPATITIS ☐ HIV+ ☐ HTN ☐ LIVER ☐ LIVER ☐ TRANSPLAI ☐ COVID	LAS	D D NAL PD HEMO ST R _X	□ SICKLE CE □ SUBSTANC ABUSE □ TB □ OTHER
ALLERGIES:			The street was		NORMAL:	Y LIN C	Gravida	Para Ab
	NURSING ASSE			LAST TETANU): 			□ N/
TIME:	☐ Interpreter	required V	ictim of Domesti	c Violence				
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	t							
					27. 14.			<u> </u>
		-						
RESPIRATORY	MUSCULOSKELETAL	SKIN/COLOR	ORIENTATION	REQUESTS	TEMP:			0 / R / T
□N/A L R	□NIA	□ WARM	□ PERSON	FROM TRIAGE		SITTING	STANDING	G LAYING
CLEAR 🗆 🗆	☐ DEFORMITY	□ DRY	□ PLACE	□ EKG	PULSE		S.a.	
CRACKLES	☐ SWELLING ☐ ABRASIONS	☐ COOL☐ DIAPHORETIC	☐ TIME /	☐ MASK APPLII	D			
WHEEZING STRIDOR U	☐ ECCHYMOSIS	☐ RASH ISOLATION	DATE CONFUSED	☐ RESP.	RESP.			
DIMINISHED	☐ LACERATION ☐ BURN	Y or N □ GOOD	□ LETHARGIC	ISOLATION □ PATIENT	BP:			
			☐ OTHER				4	1

				NAME:							*
→ TRIAGE S	SIGNATURE:	_	RN	SEX:	□м	□F	DOB:			AGE:	
MODE OF ARRIVAL:	□ AMBULANCE □ A	MBULATORY D W/	C DOTHE	R:			ACC	OMPANIE	D BY:		
PRE-HOSPITAL CAR	E: BMS PVT. AN	/IB. □ OTHER:		_ 🗆 NO	ONE E	MS VIT	ALS BP:	P:	R:	(GCS:
T _X : □ IV: A	MT ABSORBED:	□ DRSG □ C-COLL	AR □ C-SP	INE IMN	MOBILI	ZATION	☐ SPLINT	☐ SLING	OTH	ER:	es miles nects
TRIAGED TO: ENDORSED TO: CURRENT MEDICAT	□ URGENT □ N/A	E ZONE A	□ NONE	□ A □ A	EDICA ARTHRI' ASTHM/ CANCER	A [ORY HEMOPHIL HEPATITIS HIV+		PNEUMON PID PUD		□ NONE SEIZURE SICKLE CEI SUBSTANC
COMPLIAN MEDICAL	TONG.		_ NONE		CARDIA COPD CVA DIABETI DOMES VIOLENCE	ES TIC [☐ HTN ☐ LIVER ☐ LIVER ☐ TRANSPLA ☐ COVID	□ F I NT I	PVD RENAL PD HEMO LAST R _X	ПП	ABUSE B OTHER
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ALEENGIEG:	NURSING ASSE	COMENT			CHARLES STATE	ANUS:			GIATIG		□ N/A
TIME:	□ Interpreter r	required Vi	ctim of Dom	estic Vi	iolence						p T
	1										
RESPIRATORY	MUSCULOSKELETAL	SKIN/COLOR	ORIENTAT	ION	REQU	ESTS	TEMP:				D / R / T
	MUSCULOSKELETAL	SKIN/COLOR	ORIENTAT		FRO	OM	TEMP:	SITTING	G STA	NDING	D / R / T
□N/A Ł R	☐ NIA ☐ DEFORMITY	□ WARM □ DRY	☐ PERSON☐ PLACE			OM	TEMP:	SITTING	G STA		
□ N/A Ł R CLEAR □ □ CRACKLES □ □	☐ NIA ☐ DEFORMITY ☐ SWELLING ☐ ABRASIONS	☐ WARM ☐ DRY ☐ COOL ☐ DIAPHORETIC	☐ PERSON☐ PLACE☐ TIME /		FRO TRIA EKG MASK	OM	PULSE	SITTING	G STA		
N/A L R CLEAR	☐ NIA ☐ DEFORMITY ☐ SWELLING	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION Y or N	☐ PERSON☐ PLACE☐ TIME / DATE☐ CONFUS	ED 0	FRO TRIA DEKG	OM AGE APPLIED	PULSE	SITTING	G STA		
N/A L R CLEAR	☐ NIA ☐ DEFORMITY ☐ SWELLING ☐ ABRASIONS ☐ ECCHYMOSIS ☐ LACERATION ☐ BURN	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION	☐ PERSON☐ PLACE☐ TIME /	ED GIC	FROTRIAL RESP. ROLA PATIE	OM AGE APPLIED TION NT	PULSE RESP. BP:			NDING	
N/A L R CLEAR	☐ NIA ☐ DEFORMITY ☐ SWELLING ☐ ABRASIONS ☐ ECCHYMOSIS ☐ LACERATION	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION Y OF N □ GOOD □ PALE □ FLUSHED	☐ PERSON ☐ PLACE ☐ TIME / DATE ☐ CONFUS	ED GIC	FROTRIAL BEKG MASK RESP. ISOLA	OM AGE APPLIED TION NT H	PULSE RESP. BP: PULSE OX	(%		
N/A L R CLEAR	□ NIA □ DEFORMITY □ SWELLING □ ABRASIONS □ ECCHYMOSIS □ LACERATION □ BURN □ 1° □ 2° □ 3° □ WOUND CARE BITE	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION Y OF N □ GOOD □ PALE □ FLUSHED □ JAUNDICED □ CYANOTIC	☐ PERSON ☐ PLACE ☐ TIME / DATE ☐ CONFUS	ED GIC	FROTRIAL FROM TRIAL FR	OM AGE APPLIED TION NT H	PULSE RESP. BP: PULSE OX	(O GLUCOS	% SE:	NDING	
N/A L R CLEAR	□ NIA □ DEFORMITY □ SWELLING □ ABRASIONS □ ECCHYMOSIS □ LACERATION □ BURN □ 1° □ 2° □ 3° □ WOUND CARE	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION Y OF N □ GOOD □ PALE □ FLUSHED □ JAUNDICED	☐ PERSON ☐ PLACE ☐ TIME / DATE ☐ CONFUS	ED GIC	FROTRIAL FROM TRIAL FR	OM AGE APPLIED TION NT H	PULSE RESP. BP: PULSE OX	(O GLUCOS	%	NDING	
N/A L R CLEAR	NIA DEFORMITY SWELLING ABRASIONS ECCHYMOSIS LACERATION BURN 1° 2° 3° WOUND CARE BITE PUNCTURE TIME:	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION Y OF N □ GOOD □ PALE □ FLUSHED □ JAUNDICED □ CYANOTIC □ SKIN BREAKDOWN	PERSON PLACE TIME / DATE CONFUS LETHAR OTHER	GED GIC C	FRO TRIA] EKG] MASK.] RESP. ISOLA] PATIE! WATC! DATE/	OM AGE APPLIED TION VT H TIME	PULSE RESP. BP: PULSE OX FS BLOOK	(O GLUCOS	% SE:	NDING ON	
N/A L R CLEAR	□ NIA □ DEFORMITY □ SWELLING □ ABRASIONS □ ECCHYMOSIS □ LACERATION □ BURN □ 1° □ 2° □ 3° □ WOUND CARE BITE □ □ PUNCTURE TIME: □ AM	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION	PERSON PLACE TIME / DATE CONFUS LETHAR OTHER	GED GIC C	FRO TRIA] EKG] MASK.] RESP. ISOLA] PATIE! WATC! DATE/	OM AGE APPLIED TION VT H TIME	PULSE RESP. BP: PULSE OX FS BLOOK	CO GLUCOS	% SE:	NDING ON	
N/A L R CLEAR CRACKLES WHEEZING STRIDOR DIMINISHED ABSENT LABORED YES NO VITALS: T SURVEILLANCE: Have you, or a men Covid-19 in the pas	NIA DEFORMITY SWELLING ABRASIONS ECCHYMOSIS LACERATION BURN 1° 2° 3° WOUND CARE BITE PUNCTURE TIME: AM P R Therefore To your househo	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION	PERSON PLACE TIME / DATE CONFUS LETHAR OTHER	Gic DRY SUBAC	FROTRIA	APPLIED TION NT H TIME	PULSE RESP. BP: PULSE OX FS BLOOK	CO GLUCOS	% SE:	NDING ON	
N/A L R CLEAR CRACKLES WHEEZING STRIDOR DIMINISHED ABSENT LABORED YES NO VITALS: T SURVEILLANCE: Have you, or a men Covid-19 in the pas	□ NIA □ DEFORMITY □ SWELLING □ ABRASIONS □ ECCHYMOSIS □ LACERATION □ BURN □ 1° □ 2° □ 3° □ WOUND CARE BITE □ PUNCTURE TIME: □ AM P R Therefore the property of the property of your household in the property of the prop	□ WARM □ DRY □ COOL □ DIAPHORETIC □ RASH ISOLATION	PERSON PLACE TIME / DATE CONFUS LETHAR OTHER	Gic DRY SUBAC	FROTRIA	APPLIED TION NT H TIME	PULSE RESP. BP: PULSE OX FS BLOOK	CO GLUCOS	% SE:	NDING ON	D / R / T LAYING

THE MOUNT SINAI HOSPITAL EMERGENCY DEPT CHART

	LIVILITOL	INOT DEL TOTALLI					DATE
	isaster ictim #	Field Tag #					NAME
Р	atient Name:		N	_			UNIT NO. SEX/DOB
D	ate:	PMD:	0 -				SERIAL NO LOCATION
	NTIAL ME						PHYSICIAN
	INITIAL	ED PROVIDER (P	RINT)				SERVICE
_	ALLERGIES:	MD/NP ASSESSMENT	O ₂ sat	Т	P	R	BP
		□ see	choot		1:	25.00	-
	LAST TETANUS (YEARS AGO) LMP:		Sileet				
	SURG HX:	4			¥		
	SOC HX: CIGS ETOH COCAINE IVDU MEDICATIONS: SEE TRIAGE SHEET						
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	Describe all abnormal or pertinen findings ☐ N/A	t .					
	SYSTEM Specify Abnormal Norma	1			2 2		
	Eyes E.N.T.						
SYSTEMS	Cardiovascular	~:			F		
E	Respiratory						
>S	GI						
A H	GU			4: II. IP/	77		
3	Müsculoskeletal				*		
REVIE							
ä	Neuro	W					181
	Psychiatric						
	Endocrine				4		<u> </u>
	Blood/Lymph		DICT				
	Allergic/Immune	SIGN #1MI	D/NP CODE_	ENDO	RSED TO DR		AT
^	ATTENDING/PMD NOTE	SIGN #2ME	DICT D/NP CODE	DISCU	JSSED WITH DR.	<u> </u>	
	ATETIME_			aluated this patient			lan of coro
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	THE MO	UNT SINA	I HOSPIT	AL, NEW YO	ORK			DATE
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U/A: So	G PROT	GLU	KET		OOD). -		UNIT NO.
	NIT		WBC	BACTEPI	TH			SEX/DOB
			pO ₂	% Sat	A-a gradient			SERIAL NO LOGATION
ABG (F	FlO ₂) pH	pCO₂ 						PHYSICIAN/ SERVICE
						1		
					#1	J-Ib / Day	#2 Hb	/ PT PTT
EKG	#1					Wbc Pri	Het	
EKG	#2				DIF	F:	DIFF:	
		Resident / PA in	terpretation of	the ECG and agree			#1 Na	CI BUN
TIME		#2	#3			Na CI BUN GIL		CO ₂ CI Glu
CPK					_	in sever of		
МВ				* 0		DIAGNOSTIC	STUDIES/OTHER	LABS
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SEI	RVICE NAME	PHONE/BEEPER	CALLED	NEGRONDED SE				
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MS021	15 Rev. 7/06							

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

THE MOUNT SINAI HOSPITAL NEW YORK, NEW YORK	DATE
CONSULTATION REPORT	NAME
PEOLIFSTED	UNIT NO.
BY: M.D. SIGNATURE OF PHYSICIAN & SERVICE	SEX/D.O.E
NO:	SERIAL NO LOCATION
TO: M.D.	PHYSICIAL
CONSULTING PHYSICIAN OR SERVICE REASON FOR CONSULTATION:	SERVICE
CONSULTANT'S FINDINGS: (HISTORY AND PHYSICAL)	
· · · · · · · · · · · · · · · · · · ·	
OPINION AND RECOMMENDATIONS:	
DATE TIME M.D M.D	ITLE OF CONSULTANT

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

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						S	TAPLES PRIN	ACTUDOS TR	JS (212) 462-7	7586				300482	

THE MOUNT SINAI HOSPITAL, NEW YORK
EMERGENCY DEPARTMENT ASSESSMENT RECORD
CONTINUATION SHEET

NAME:			i 1 1 1 1				
#:			 	0 2			
DATE:			 		Pag	e#	ę
Date/Time	Vital Signs:	Progress Notes:		7			7
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EMERGENCY DEPARTMENT CUSTOMIZED LAB REQUISITION

Requesting Physician Name:

Provisional Diagnosis:

NAME

(212) 241-5227

Sinai

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.

JΑ	

UNIT NO.

SEX / DOB

PHYSICIAN

PHYSICIAN'S SIGNATURE MANDATORY FOR MEDICAID PATIENTS Physician's Dict. Code: Request Date: Time: Collection Date: Time:

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

	MISCELLANEO	US LIST	ING			TITERS		MICROBIOLOGY
1104	ACETONE	4272	HEPATITIS B CORE AB		4330	ASLO	4305	B STREP, THROAT CULTURE
1105	ALBUMIN	4277	HEPATITIS C VIRUS AB		4622	CMV	404	BLOOD CULTURE
1134	ALKALINE PHOSPHATASE	703	HEMOGLOBIN A1C L		432	CRYPTO, AG SERUM	499	C&sOTHER
1143	ALT (SGPT)	855	IMMUNOELECTRO	4	4633	EBV AB	497	EYE CULTURE
1107	AMMONIA	1146	LACTATE GY 1		4624	HERPES AB	P994	CHLAMYDIA / GC PROBE
1109	AMYLASE	1130	LDH		4550	LYME - SERUM	415	FUNGAL CULTURE
1142	AST (SGOT)	1783	LIPASE		4621	TOXO, AB		SOURCE:
379	BHCG (QUAL) SERUM	1131	MAGNESIUM		4612	VARICELLA - ZOSTER	463	HERPES VIRUS CULTURE
323	BHCG (QUANT) SERUM	315	OSMOLALITY				480	AFB CULTURE & SMEAR
378	BHCG - URINE	747	PROLACTIN					SOURCE:
733	B12 / FOLATE L	1443	PROTEIN FLUID				461	RSV CULTURE
1112	BILIRUBIN, TOTAL		SOURCE			CSF TESTS	470	SPUTUM CULTURE
877	C-REACTIVE PROTEIN	1140	PROTEIN, T	SPE	CIALT	Y TUBE #:	400	URINE CULTURE
1116	CALCIUM	345	PT B	TUBI	E#	CELL COUNT	440	WOUND CULTURE
202	CBC, PLT L	346	PTT B	TUBI	E#	C & S, GRAM STAIN AND	460	VIRAL CULTURE
3332	CARBOXY HEMA, ARTERIAL	380	Q-STREP		(CIF	RCLE)		SOURCE:
3342	CARBOXY HEMA, VENOUS	206	RETIC COUNT L		CIE	AFB Indink CRYPTO	4646	C. DIFFICULE TOXIN STOOL
724	CORTISOL	880	SERUM PROTEIN ELEC.		HEF	RPES: LYME VIRAL	450	CULTURE STOOL
1120	CPK	420	SYPHILIS RPR SCREEN	TUB	}E#	CHEM: PROT GLU	454	OVA AND PARASITE STOOL
1121	CREATININE	221	URINALYSIS	TUB	BE#	(CIRCLE)		
2528	D-DIMER B	1270	VALPROIC ACID		CEL	LCOUNT VDRL		
1111	DIRECT BILI		·			ADDITION	IAL TES	TS
210	ESR B							
1400	FE/TIBC							
275	FLUID CELL Count & Diff.					DRUG /	ASSAYS	
1442	GLUCOSE FLUID				1149	ACETAMINOPHEN	1163	PHENYTOIN
	SOURCE				1178	ALCOHOL	1795	PROGRAF
8069	HEPTOGLOBIN R				1193	CARBAMAZEPHINE	1141	SALICYLATES
4273	HEPATITIS A AB (IGM)				1194	DIGOXIŃ	1101	THEOPHYLLINE
4261	HEPATITIS B SURFACE AB		NACON PRODUCTION OF THE PRODUC		1103	LITHIUM	1203	TRICYCLICS (QUAL)
4271	HEPATITIS B SURFACE AG		New 2015 New 2015 Co.		1164	PHENOBARB	1270	VALPROIC ACID

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	6	DATE:
REQUEST FOR RADIOLOGY CONSULTATION		NAME:
CLINIC NAME: CLINIC #: RETURN DATE:		UNIT NO/ SEX/DOB;
EXAM(S): (indicate if contrast is desired)		SERIAL NO/ LOCATION:
	90	PHYSICIAN/ SERVICE:
MANDATORY: CLINICAL DIAGNOSIS & OTHER PER	RTINENT INFORMATION	FOR IV CONTRAST STUDY:
		DATE
,		BUN:
		CREAT:
ALLERGIES: YES NO SPECIFY:	PREGNANT?	YES NO LMP:
IV CONTRAST CONTRAINDICATED: YES NO □	RADIOLOGIST COMME	ENTS:
STAT ☐ PORTABLE ☐ ISOLATION ☐		·
PT. ABLE TO STAND YES NO PT. ABLE TO SIT YES	NO 🗌	
TRANSPORT WIC STR IV POLE OXYGEN PHYSICIAN OR NURSE MUST ACCOMPANY PATIENT RECEIVING BLOOD OR OXYGE	N .	
MANDATORY: REQUESTING MD'S SIGNATURE REQUESTING MD (PLEASE PRINT)	BEEPER#: PHONE#:	DICT. CODE:
D. F. A. 20. Dev. (5/20)		

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

30.0 NE

eNT. SE¥CC8

SERIAL =/

PHYSICIAN/ SERVICE

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

ALLERGIES: NAME: DOB **ORDERS** Use Full Block for Nebulizer Orders. PRESCRIBER'S SIGNATURE DATE RN SIGNATURE TIME DATE RN SIGNATURE TIME PRESCRIBER'S SIGNATURE DATE TIME DATE RN SIGNATURE DATE PRESCRIBER'S SIGNATURE TIME DATE 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	RN/ LPN	
D/31 L	3 11000	ORDER	1	
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PHARMACY DRUG DIRECTIONS FOR USE **ALLERGIES: (Must be completed)** <u>.</u> SUB. Q. Z **MEDICATION RECEIVED** ROUTE OF ADMINISTRATION FLOOR COPY KEEP UNTIL VAGINAL RECTAL ORAL NASAL OTIC OPHTH TOPICAL RESIDENT ATTENDING FILLED OUT BY Circle or write in dosage form. Addressograph imprint must be clear. Please write legibly and in ink. THE MOUNT SINAI HOSPITAL NEW YORK DRUG REQUISITION EXT. 47714 OR 5 LIQUID CA_P TAB INPATIENT POTENCY/DOSE DOSAGE FORM DROP CREAM **OINTMENT** SUPPOS POWDER R M. B-2-C-1B (REV. 8/99) QUANTITY ORDERED THIS SPACE WRITE IN DO NOT SCANCE ANDIONALLA NOUTPOOT RODARS FOR BASE 2 NAME FLOOR COPY

THE MOUNT SINAI HOSPITAL - NEW YORK

	REQUEST FOR BLOOD COMPONENT	PONENT		1	
DATE OF REQUEST	/ / RECEIVED BY	TII	TIME		DATE
REQUESTED BY DR	R (SIGNATURE) DICTATION NO	TATION NO			
DISPENSED BY		188	TIME		
CHECK BOX	CHECK BOX 🗍 NEXT TO COMPONENT REQUEST AND INDICATE NO. UNITS - IF	IDICATE NO. UN	VITS - IF		NAME
PATIENT REQU "OTHER"	PATIENT REQUIRES UNLISTED PRODUCT. INDICATE PRODUCT AND UNITS UNDER "OTHER"	JCT AND UNITS	UNDER		/ON TINII
CODE	PRODUCT	ONE UNIT	NO. UNITS	ITS	SEX/DOB
143004	☐ PACKED RED CELLS	200 ml			
143002	☐ WHOLE BLOOD	450 ml			LOCATION
143020	☐ FROZEN RED CELLS	200 ml			
143154	☐ WASHED RED CELLS	200 ml			PHYSICIAN/
143288	☐ FILTERED RED CELLS *	200 ml			SERVICE
143006	□ PLATELETS, POOLED	UNIT		TO BE COMPLETED BY BLOOD BANK	
143290	□ PLATELET, SING. DONOR	UNIT			
143282	□ PLATELETS, HLA MATCH *	UNIT		PATIENT'S BLOOD TYPE	1
143016	☐ FROZEN PLASMA (Fresh)	250 ml		IDENTIFICATION #	
143080	☐ RHOGAM	VIAL			1
143256	☐ IRRADIATION *				1-
143010	☐ CRYOPRECIPITATE	UNIT		2.	l
143082	☐ LEUKOCYTES *	UNIT		»	
143248	☐ STIMATE (DDAVP)	VIAL		Q.	!
143214	☐ FEIBA	UNIT		4.	İ
	☐ FACTOR VIII	UNIT		cn	
	☐ FACTOR IX	UNIT		C	ļ
	□ OTHER			9.	
* Subject to Bl	* Subject to Blood Bank approval	REA	SON FO	REASON FOR REQUEST (Must be completed or request will be delayed!!)	
DIAGNOSIS:				SURGICAL/INVASIVE PROCEDURE:	☐ YES
HEMOGLOBIN	GM/dL HEMATOCRIT		%	Anticipated/Estimated Blood Loss	ML
PLATELET	uL WBC		논	BLEEDING: YES	
PT I	_SEC/SEC PTTS	SEC/	SEC	IMMUNOSUPPRESION: YES	
FIBRINOGEN	MG/dL	ďL		Rh INCOMPATIBILITY: TES	
BLEEDING TIME	ÆMIN			TRANSFUSION HISTORY PREGNANCY	
FACTOR		%		OTHER REASON:	
FORM # ZNYMSD8A4 (REV. 12/20)	A4 (REV. 12/20)				ă



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PAGF	OF									DAT
			IISTRATION O	FP	PATIENT CONTRO	LLED				INU
ANAL	GESIA (PCA),	EPIDURAL, N	ER	VE BLOCK AND					SEX SEF
					PCA, EPIDURAL,	UTDOLLED				NO.
			ANALGESICS		NFUSION OF CO	NIROLLED				PHY
					□CONTINUOUS	PAIN SERV	CE ONLY			SEF
	ROmorp					☐ FENTANYL		VAC	AINE	EPIDURAL
	ITANYL 2		_				+ BUP			EPIDURAL
	AZOLAM	~				□ OTHER				EPIDURAL
		_	E 1 mg/mL				INE 0.1% PERIP	HER		
			.5 mg/mL PEDIA	TRI	С	☐ BUPIVACA			AL NERVE C	
OTH										
EPIDL	JRAL				•					
FEN	ITANYL 5	mcg/m	L + BUPIVACAI	NE (D.1% CASSETTE					
BUF	PIVACAIN	E 0.1%	CASSETTE							
				50 160	PUMP SE	TTINGS				
DATE	TIME	CON	TINUOUS RATE	P	CA DOSE	PCA DOSE	MAX PCA		HOURLY	SIGNATUR
		□ме	a □ MCG □mL	1	MG MCG mL	LOCKOUT (MIN)	DOSES/HOUR	DE	LIVERY LIMIT	TITLE
				-				-		
DATE		T INITIA	ATION/ DISCONT	-	IATION OF THERAP	Y, CHANGE OF SI VOLUME IN BAG				NSFERRED TURE/ TITLE
			LOCATION		IG □ MCG □mL	(mL)	INFUSED (1	nL)		
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DAT	E	TIME	PATIENT LOCATIO		VOLUME DISCARDED	SIGNATU	RE/ TITLE		SIGNATU	RE/ TITLE
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			RECORD	OF	RETURN TO PH	IARMACY - A	NESTHESIA	ONI	LY	
DAT	E	TIME	PATIENT	Г	VOLUME	SIGNATU	RE/ TITLE		SIGNATU	RE/ TITLE
			LOCATIO	N	RETURNED					
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Emergency Department				DATE
PATIENT DISCHARG				NAME
NAME:	-			UNIT= SEX/DO
MR #:				SERIAL:
	formation about the care you received primation about caring for yourself a good need additional treatment.			PHYSICI SERVICI
You were seen by	Name of Provide	er	on	date
		Instruct		
Discharge Diagnosis Diet Recommendation		msuuc		
		to work/school in		
MEDICATION PRES		WOLK SOLLOUI III		
Name	Dose	Duration		Purpose
ADDITIONAL INSTRUCTI	IONS			
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RETURN TO THE EMERG FOLLOW-UP CARE Own physician	EENCY DEPARTMENT IMME	EDIATELY IF SYMPTOMS WORSweeks.		TOMS OCCUR O
FOLLOW-UP CARE Own physician Please stop at Discharge Des	EENCY DEPARTMENT IMME indays	DIATELY IF SYMPTOMS WORS weeks. cleaving.		TOMS OCCUR O
FOLLOW-UP CARE Own physician Please stop at Discharge Des	EENCY DEPARTMENT IMME in days k to receive appointment before	weeks.		TOMS OCCUR O
FOLLOW-UP CARE Own physician Please stop at Discharge Des	in days k to receive appointment before Clinic in d clinic in d king day (Monday-Friday 8AM-	weeks. eleaving. ays weeks. ays weeks. eleAPM) for appointment to		IOMS OCCUR O
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MEDICAL RECORDS

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