St. Mary's Medical Center - Emergency Department
TRIAGE ASSESSMENT FORM

CHEST PAIN PROTOCOL

Date/Time stamp: 01/28/2025 - 22:47

PATIENT INFO BOX

PATIENT NAME: John Smith
DOB: 08/14/1968 (age 56)
MRN: 612-445289
ARRIVAL TIME: 22:47
ARRIVAL MODE: Self (walked in)
TRIAGE NURSE: K. Rodriguez, RN

22:47

CHIEF COMPLAINT

Chest pain x 2 hours, radiating to left arm
- Pt states pain started while watching TV at home around 8:30pm
- Describes as "pressure" and "heavy feeling"
- Denies trauma, recent illness. Some nausea. Sweating.
- Wife drove him to ER. Pain 7/10.

INITIAL VITAL SIGNS

22:52

Time: 22:52	BP: 156/94	HR: 92 bpm	RR: 18	Temp: 98.4°F	O_2 SAT: 96% RA	Pain Scale: 7/10

TRIAGE ASSESSMENT

- Gen: Alert, anxious, diaphoretic (sweating)
- Appearance: Well-nourished male, clutching chest
- Skin: Pale, cool, clammy
- Quick cardiac: Pulse regular, no obvious murmur on brief listen

PAST MEDICAL HISTORY

☒ Hypertension (on meds) ☒ High cholesterol ☐ Diabetes
☒ Smoker – "1 PPD x 30 years" ☐ Previous MI
Meds: Lisinopril, Atorvastatin

ALLERGIES

NKDA (No Known Drug Allergies)

TRIAGE DECISION: ****ESI LEVEL 2 - EMERGENT****
Possible ACS – EKG and labs STAT → To Trauma Bay 3
Provider notified: Dr. J. Chen

22:55

NURSE SIGNATURE K. Rodriguez RN **Time:** 22:55

STEMI ALERT

St. Mary's Medical Center - Emergency Department
PHYSICIAN EVALUATION NOTE

Patient: Smith, John | MRN: 612-445289 | DOB: 08/14/1968
Date: 01/28/2025 | Provider: Dr. Jennifer Chen, MD TIME OF EVALUATION: 23:15

HISTORY OF PRESENT ILLNESS
56 yo M presents c/o chest pain x 2h. Pain started at rest while watching TV ~2030. Describes as "pressure" substernal, 7/10 severity, radiating to L arm. Associated with diaphoresis, mild nausea. Denies SOB, palpitations, prior similar episodes.

PMH: HTN, hyperlipidemia, 30-pack-year smoking history
Meds: Lisinopril 20mg daily, Atorvastatin 40mg daily
Social: Works as accountant, married, 2 adult children

] + father had MI age 62

PHYSICAL EXAM
VS: BP 148/88, HR 88, RR 16, O2 97% RA, Temp 98.4°F
Gen: Alert, anxious but cooperative male in mild distress
HEENT: PERRL, no JVD
CV: RRR, no m/r/g, distal pulses intact bilaterally (no radiation, equal)
Resp: CTAB, no wheezes/rales
Abd: Soft, NT/ND, + BS
Neuro: A&Ox3, no focal deficits

EKG INTERPRETATION
ST elevation 2-3mm in leads II, III, aVF
Reciprocal ST depression in I, aVL → STEMI ALERT CALLED 23:18

LAB RESULTS 23:10
Troponin I: 1.8 ng/mL (ELEVATED - marked in red)
CK-MB: 12 ng/mL
BNP: 180 pg/mL
CBC: WNL
BMP: WNL
Lipid panel pending

IMAGING
CXR: No acute process, normal cardiac silhouette

IMAGING
CXR: No acute process, normal cardiac silhouette

ASSESSMENT
ACUTE INFERIOR STEMI
- Ongoing chest pain despite aspirin, nitro
- Elevated troponins, + EKG changes
- High risk features

PLAN
☑ Aspirin 325mg given
☑ Plavix 600mg loading dose
☑ Heparin drip initiated
☑ Morphine 4mg IV for pain 23:20
☑ Cardiology consult - Dr. Patel paged STAT
☑ Cath lab activated - ETA 30 min (mobilizing team now)
→ EMERGENT PCI
→ Transfer to CCU post-procedure

STEMI PROTOCOL INITIATED: 23:18
Door-to-balloon target: <90 minutes

Door to EKG: 23:12
EKG to Alert: 23:18
Alert to Cath Lab: 23:22

PATIENT EDUCATION
Explained heart attack, need for urgent cath. Risks/benefits discussed, pt agrees to proceed. Wife at bedside, both understand plan.

CODE STATUS
Full code (confirmed with patient)

DISPOSITION
Direct admit to Cath Lab → CCU
Critical care level
Cardiology primary team (Dr. Patel)

PHYSICIAN SIGNATURE
J. Chen, MD, FACEP 01/28/2025 23:25

FOOTER NOTES
TIME-SENSITIVE EMERGENCY
STEMI PROTOCOL ACTIVE