

## H1N1 Outpatient Triage Sheet

Patient Name:				Date/Time of Call:	
Age:	G	P	EDD	EGA	Allergies:
<b>Review of Influenza Like Symptoms</b>					
Fever >100.0	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset	/ / 20	Highest Temp:
Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset	/ / 20	
Sore Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset	/ / 20	
<b>Pertinent Medical History</b>					
Chronic Lung Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Immunosuppressed	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Recent Exposure to H1N1	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Family Member with H1N1	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Seasonal vaccine	<input type="checkbox"/> No	<input type="checkbox"/> Yes	H1N1 Vaccine	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Date Vaccine Received	/ /		Date Vaccine Received	/ /	
Vaccine Received at:			Vaccine Received at:		
<b>Consider Admission to Hospital if "YES" to any of the Following</b>					
SOB/Difficulty Breathing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset		
Bloody or Colored Sputum	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset		
Dizziness/Confusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset		
Chest/Abdominal Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset		
Sever or Persistent Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset		
Symptoms Improved Then Returned with Fever and Worsening Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Onset		
Other Symptoms					
<b>Disposition</b>					
Treat as Outpatient	Rx: <b>Tamiflu</b> <input type="checkbox"/> Prophylaxis 75 mg po daily for 10 days <input type="checkbox"/> Treatment 75 mg po BID for 5 days				
	<input type="checkbox"/> Prescription Given <input type="checkbox"/> Prescription Called to: By:				
		<input type="checkbox"/> Isolation precautions discussed			
Admit For Inpatient Treatment	<input type="checkbox"/> Admit to:				
<b>Follow-Up Assessment</b>					
<input type="checkbox"/> Call in 24 Hours		<input type="checkbox"/> Call in 48 Hours		<input type="checkbox"/> Call in 72 Hours	
Comments:					

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_