### Altered Calling Criteria

**Additional RED ZONE Criteria**
- Cardiac or respiratory arrest
- Altered calling criteria

**Additional YELLOW ZONE Criteria**
- Oxygen saturation less than 94%
- Fluctuating or 2-point drop in GCS
- Temperature less than 36°C or greater than 38°C

### Additional Observations

**DEPARTMENT OBSERVATION**

**ALL OBSERVATIONS MUST BE GRAPHED**

**Clinical Review**
- Senior Medical Officer or Nurse review within 10 minutes.
- Observations recorded at least 15 minutes.
- Must have continuous monitoring.

**Rapid Review**
- Senior Medical Officer or Nurse review within 30 minutes.
- Observations recorded at least 30 minutes or the first hour and then hourly thereafter.
- Consider the need for continuous monitoring.
- Postoperative care if/when indicated.

**INR**

**Blood Glucose Level**
- ≥ 4 mmol/L
- < 4 mmol/L or > 20 mmol/L over 8 hours or < 0.5 mL/kg/hr via an IDC)

**Serum Lactate**
- pH < 7.2 or BE < -5

**Temperature**
- Temperature (°C) •
- 34.5
- 35.5
- 36.5
- 37.5
- 38.5
- 39.5
- 40.5

**Blood Pressure (mmHg)**
- SBP
- 100
- 110
- 120
- 130
- 140
- 150
- 160
- 170
- 180
- 190
- 200
- 210
- 220

**Heart Rate**
- ≥ 100
- 100
- 110
- 120
- 130
- 140
- 150
- 160
- 170
- 180
- 190
- 200

**Respiratory Rate**
- ≥ 20
- 20
- 25
- 30
- 35
- 40

**GCS**
- GCS/PUPIL RESPONSE KEY
- 1 - None
- 2 - Incomprehensible
- 3 - Inappropriate
- 4 - Withdraws
- 5 - Localises to Pain
- 6 - Obeys Commands

**GCS/ PUPIL RESPONSE**

**GLASGOW COMA SCALE**

**BEST VERBAL**
- None
- Confused
- Complains
- Responds
- Obeys

**BEST MOTOR**
- None
- Flexion
- Extension

**TOTAL**

**RELAXATION SCALPE**
- 1
- 2
- 3
- 4
- 5

**RELAXATION SCALE**

**FLUID BALANCE CHART**

**FLUIDS**
- Intravenous
- Total
- Prog.

**TOTAL**
- Prog.
- Other
ADULT EMERGENCY
DEPARTMENT OBSERVATION
CHART

SUBSTANCE USE SCREEN

1. Does the patient currently smoke? NO  YES
2. Has the patient recently used any other drug? NO  YES
3. Has the patient recently used alcohol? NO  YES

FALLS RISK SCREEN

Is the patient wearing the correct shoes and clothing? NO  YES
Is the patient aware of the risk of falling if they lose balance? NO  YES
Is the patient wearing any support device? NO  YES

WATERLOW PRESSURE ULCER PREVENTION ASSESSMENT

Circle the appropriate score in the table below and calculate the total to obtain risk score

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Continence</th>
<th>Skin type visual risk</th>
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<td>0 = Not applicable</td>
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<td>3 = 10 – 15 kg</td>
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<td>5 = Peripheral vascular disease</td>
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OTHER CHARTS

ADMISSION CHECK

Presenting Problem: ...
Protocol Commenced: ...
Contact person: ...
Religiou: ...
Contact method of notification: ...
Contact person aware of notification: ...
Religious requirements: ...
Language: ...

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MALTUNION SCREENING TOOL (MST) – CIRCLE AND ADD FOR A TOTAL

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