

# Northwick Park Hospital Emergency Department

Date:

Clinician:

Time seen:

First name:

Last name:

DOB:

Hospital number:

**PRIORITY CALL**

Call sign:

CAD:

Age/sex:

ETA:

RR:

SpO<sub>2</sub>:

HR:

BP:

GCS:

BM:

T:

BLUE / TRAUMA / CPR

Arrival time in resus:

Presenting complaint:

Accompanied by:

History of Presenting Complaint:

**Safeguarding Questions:**

History consistent with injury/ illness?	Y	N
Injury/ illness consistent with age & Development?	Y	N
Unexplained delay in seeking treatment?	Y	N
Unexplained injuries?	Y	N
Concern about appearance/ interaction?	Y	N
FGM concerns?	Y	N
Other safeguarding concerns?	Y	N
Alerts on the system?	Y	N
History/ suspicion of domestic violence, mental health problems, learning difficulties or drug/alcohol abuse in carer?	Y	N
No of previous NWLH ED attendances:		

Past medical history:

Birth history:

Developmental history:

**Allergies:**

Drug history:

Immunisation status:

Up-to-date / Unimmunised

Other: \_\_\_\_\_

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## Family history:

Family tree:

Parents / Carers:

Name:                    DOB/Age:                    Occupation:

Name:                    DOB/Age:                    Occupation:

## Social history:

Nursery/ school:

Named social worker (if applicable):

Smoking/ drugs/ alcohol: (In adolescents think HEEADSSS\*)

Housing: Private / council

No of bedrooms:

## Family Well-Being Screening\*\*:

1. Have you been worried that you would not be able to pay your bills? Y  N
2. Have you been worried that your food would run out before you had money to buy more? Y  N
3. Have you had any problems with your housing? Y  N

## Observations:

HR                    BP                    RR                    SpO<sub>2</sub>                    on RA/oxygen .....                    Temp.                    GCS                    PEWS

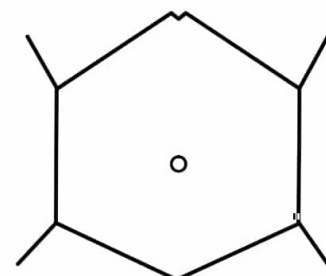
On examination:

CVS:

ENT:

Skin:

Neuro/ Other:



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## Diagnosis:

## Plan:

Discussed with patient and carers:

## Results:

CXR:

Urinalysis:

ECG:

Bloods/ blood gas:

## Outcomes:

Consultant/ Registrar signature:

COU  Time:

Reason for COU:

Clinician reviewing on COU: (name)

Paediatrics / ED / Specialty (team)

COU proforma completed

Referral

Specialty:

Name:

Time:

Ward

Drug chart:  Admit on EPRO :  Handover to ward team (#349) :  Safeguarding referral (if applicable)

Discharge  Time:

Name:

Signature:

GMC/HCPC/PANVR:

\* Consider using HEEADSSS assessment when reviewing adolescents/ young people/ children presenting in mental health crisis. This includes asking about: **H**ome, **E**ducation, **E**ating, **A**ctivities, **D**rugs, **S**exuality, **S**uicide, **S**afety/ **S**ocial media. Well being guides are available on the intranet.

\*\* Remember to complete the Family Well-Being Screen. If child/ parents answer yes to any of the questions then give them a 'Family Wellbeing' leaflet available in the department or on the intranet. Emergency food parcels are available in the ED.

