MedStar PromptCare

EMERGENCY SCREENING

Welcome to MedStar PromptCare. In order to provide the very best care for you and also protect your privacy, we ask that you complete this form immediately upon presentation to the practice and provide it to the front desk associate at the reception desk.

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Primary Care Clinician or Practice: _____

REASON FOR YOUR VISIT TODAY: _____

Is today's visit related to work place injury? ❑ Yes ❑ No
Is today's visit related to an auto accident? ❑ Yes ❑ No

IF YOU (OR THE PATIENT) ARE EXPERIENCING ANY OF THE FOLLOWING AT THIS TIME PLEASE CIRCLE THE SYMPTOM/EVENT:

1. **Chest pain** (not associated with coughing or flu symptoms), pressure or heaviness in the chest, chest pain that radiates into the shoulder, arm, back or jaw, heart attack
2. Difficulty breathing, **shortness of breath**, asthma attack
3. Severe or uncontrolled **bleeding**
4. Loss of consciousness, **fainting** or **seizure**
5. Foreign object in the **eye** or chemicals splashed in the eye
6. Medication **overdose** or ingestion of a chemical
7. Sudden onset of one-sided extremity or facial weakness, difficulty speaking, blurred vision, dizziness, headache, confusion, disorientation or other symptoms of a **stroke**
8. Possible contagious **rash** (such as chickenpox, scabies, measles)
9. Fall, injury or motor vehicle crash with neck pain, headache, **head injury**, numbness, weakness or tingling in the extremities
10. Severe **abdominal pain**, testicular pain or pregnancy with severe abdominal pain

Staff Reviewed
Initials: _____
Time: _____
Placed in Mask
Y or N (circle)

Please wear a mask for fever, chills, cough, rash with fever or body aches, runny nose, red eyes, sore throat, sensitivity to light, neck stiffness, headache or swollen cheeks face or neck.

_____

_____ _____ _____
Signature Date Time

_____ _____
Name of Representative Signing for Patient Relationship of Representative to Patient
(Required if the patient is a minor or an adult unable to sign this form)

STAFF USE ONLY IF NEEDED IN AN EMERGENCY

Vital Signs:
BP: ____/_____ Height: _____cm Weight: _____kg Pain: _____

Temp: _____C Pulse: _____ Resp: _____ SpO2:_____% Time: _____ Initials: _____

Address:_____ Employment Status:_____ Marital Status: _____

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

Who is the Policy Holder of the Insurance: _____ DOB of Policy Holder: _____

1-8-19 wkm