

MEDICAL OFFICE TRIAGE FORM

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Emergency Contact Name: _____ Phone Number: _____

Reason for Visit / Chief Complaint:

Triage Nurse Assessment:

Initial Vital Signs:

Blood Pressure (mmHg): _____

Heart Rate (bpm): _____

Respiratory Rate (per min): _____

Temperature (°F): _____

Oxygen Saturation (%): _____

Triage Category / Acuity Level:

Emergent Urgent Non-Urgent Routine

Allergies:

Current Medications:

Past Medical History / Significant Conditions:

Symptoms Description:

Pain Assessment:

Location: _____

Intensity (0-10): _____

Quality / Type: _____

Duration: _____

Additional Observations / Notes:

Triage Nurse Name and ID: _____

Signature: _____

Time of Triage: _____

I acknowledge that the information provided on this triage form is accurate and complete to the best of my knowledge. I understand that this information will be used by medical staff to prioritize care and that this form does not constitute a comprehensive medical assessment.

Patient / Guardian Signature: _____

Date/Time: _____

Triage Nurse Signature

Patient / Guardian Signature

Signature: _____

Signature: _____

Date/Time: _____

Date/Time: _____

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