Annex 1: Triage form for health facility (adults)

DETAILS OF THE FACILITY	**PATIENT DETAILS**
HEALTH FACILITY NAME ……	Hospital reg. Number ……
REGION……..	Surname ……
DISTRICT……	Other names ……
P.O Box ……..	Address (*district of domicile*) ……
Tel: +255 ……	Phone contact……
Allergies (Yes/No)	Date of Birth ……/……/…… (*If No age:* Child / Adult Sex
If yes mention ……	……
	Religion ……

TRIAGE			
Date: _____	**Time:**_____	**Providers name:**	_____
Chief Complaint	Medical		
	Trauma		

VITAL SIGNS	**BP____/____**	**Pulse____/min**	**RR_____/min**	**SPO_2_____%**	**Temp: ^oC**

TRIAGE CATEGORY					
EMERGENCY Criteria				**Tick here if Yes**	
	Unresponsive / Altered mental status			Pregnant with vaginal bleeding	
	Noisy breathing			Pregnant with Severe abdominal pain	
	SpO_2 <90%			Pregnant with Seizures (history or active)	
	Respiratory distress			Pregnant with Severe headache	
	Capillary refill>3 sec			Pregnant with Visual changes	
	Hear rate <50 or > 150)			Pregnant with SBP≥160 or DBP ≥110	
	Active bleeding			Pregnant with Active labour	
	Active convulsions			Pregnant with Trauma	
	Poisoning or dangerous chemical exposure*			Acute chest pain	
	Violent or aggressive behavior			Facial burn	
	SBP≥180 or DBP ≥110				
PRIORITY Criteria				**Tick here if Yes**	
	Vomits everything or ongoing diarrhea			Severe pain	
	Unable to feed or drink			Visible acute limb deformity/dislocation	
	Severe pallor			Open fracture	
	Recent fainting			Burns except facial burn	
	Sexual assault			Exposure requiring time- sensitive prophylaxis (example: animal bite, Snake bite , needle-stick injury)	
	Acute general weakness			Referral patient (no emergency criteria)	
	Acute focal neurological deficit			New rash worsening over hours or peeling	
	Acute visual disturbance			Old age (>60yrs)	
QUEUE Criteria				**Tick here if Yes**	
	Patient with no Emergency or priority criteria indicated in above tables				