



DRO # _____ DRO Name _____ DRO Date _____ Case # _____
Service Delivery Site _____ City/County/State _____ CAS # _____

Client Information

Name (Last, First) _____ Primary Language _____
Age _____ Date of Birth _____ Male Female Other Veteran Yes No
Pre-Disaster Address _____
Current Address _____ Phone # _____
Alternate Contact Name _____ Phone # _____
Caregiver: Home Health Provider Parent Spouse Friend None Other
Name _____ Phone # _____

Allergies

List all medication, environmental and food allergies, and include type of reaction.

Insurance Information and Medical History

Policyholder Name _____ Policy Phone # _____ Policy # _____
Health Care Provider _____ Provider Phone # _____
Treatment & Release Date _____ Hospitalized Yes No Where _____
Medical History _____

Current Medication	Dosage	Last Dose	Current Medication	Dosage	Last Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmacy Name _____ Phone # _____

Psy START Mental Health Triage

Risk factors identified by Disaster Health Services and Disaster Mental Health. Do not ask the client about these risk factors directly. These risk factors should be identified during client interaction.

*** Contact site manager and DMH immediately or call 911 ** Contact DMH as soon as possible and document referral * Contact DMH at end of shift and document referral on the Client Health Record

- | | |
|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> ***Danger to self or others | <input type="checkbox"/> **Trapped or delayed evacuation |
| <input type="checkbox"/> **Felt/expressed extreme panic or fear | <input type="checkbox"/> **Family member currently missing or unaccounted for |
| <input type="checkbox"/> **Felt direct threat to life of self and/or of family member | <input type="checkbox"/> **Unaccompanied child |
| <input type="checkbox"/> **Saw/heard death or serious injury of other | <input type="checkbox"/> *Home not livable |
| <input type="checkbox"/> **Death of parent, child or family member | <input type="checkbox"/> *Separated from immediate family during event |
| <input type="checkbox"/> **Death of pet | <input type="checkbox"/> *Prior history of mental health care |
| <input type="checkbox"/> **Significant disaster-related illness or physical injury to self or family member | <input type="checkbox"/> No triage risk factors identified |

Primary complaints and notes continued on page 2

Client Name (Last, First) _____ Case # _____ CAS # _____

Primary Complaints

Check all complaints that apply to the current visit under each category related to the patient's main reason(s) for seeking care. Do not record client's medical history in this area. For follow-up visits, enter the date next to the box to update the notes section.

Date of Injury _____	Acute Illness/Symptoms (Cont'd)	Care
<p style="text-align: center;">Type of Injury</p> <input type="checkbox"/> Abrasion, cut, laceration <input type="checkbox"/> Avulsion, amputation <input type="checkbox"/> Concussion <input type="checkbox"/> Bruise, contusion <input type="checkbox"/> Fracture <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Other _____	<input type="checkbox"/> Cardiac event <input type="checkbox"/> Fever (>100.4°F or 38°C) <input type="checkbox"/> Heat related illness symptoms <input type="checkbox"/> Cold-related condition symptoms <input type="checkbox"/> Extreme fatigue or overexertion <input type="checkbox"/> Eye irritation <input type="checkbox"/> Dehydration symptoms <input type="checkbox"/> Gastrointestinal: <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea (bloody or watery) <input type="checkbox"/> Respiratory: <input type="checkbox"/> Shortness of breath or difficulty breathing <input type="checkbox"/> Chest congestion <input type="checkbox"/> Congestion, runny nose, sinusitis <input type="checkbox"/> Sore throat <input type="checkbox"/> Wheezing in chest <input type="checkbox"/> Cough <input type="checkbox"/> Influenza-like-illness (ILI) (fever of 100.4°F or 38°C or greater AND cough and/or sore throat) <input type="checkbox"/> Skin: <input type="checkbox"/> Generalized rash <input type="checkbox"/> Localized rash <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> Fungus, ring worm, tinea <input type="checkbox"/> Obstetrics/Gynecology: <input type="checkbox"/> Vaginal bleeding outside of pregnancy <input type="checkbox"/> Pregnancy - abdominal cramping <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Pregnancy complications <input type="checkbox"/> Neurological, specify: _____ <input type="checkbox"/> Mental Health: <input type="checkbox"/> Behavior: <input type="checkbox"/> Depressed mood <input type="checkbox"/> Anxiety or stress <input type="checkbox"/> Disruptive <input type="checkbox"/> Agitated <input type="checkbox"/> Suicidal or homicidal thoughts <input type="checkbox"/> Psychotic symptoms (e.g. hallucinations, paranoia) <input type="checkbox"/> Drug/alcohol intoxication / withdrawal <input type="checkbox"/> Not specified elsewhere, specify: _____	<input type="checkbox"/> Blood pressure check <input type="checkbox"/> Dressing change / wound care <input type="checkbox"/> Medication refill <input type="checkbox"/> Blood sugar check <input type="checkbox"/> Immunization / vaccination <input type="checkbox"/> Pregnancy / post-partum assessment <input type="checkbox"/> Other _____ <p style="text-align: center;">Exacerbation of Chronic Illness <i>ONLY if current visit related. Do not record patient HX.</i></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer, <i>specify</i> _____ <input type="checkbox"/> Renal disease / dialysis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Hypertension <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Coronary heart disease (e.g. MI) <input type="checkbox"/> Cerebrovascular disease / stroke <input type="checkbox"/> Chronic joint pain (e.g. arthritis) <input type="checkbox"/> Obstructive pulmonary disease <input type="checkbox"/> Previous Mental health diagnosis, <i>specify:</i> _____ <input type="checkbox"/> Other _____
<p style="text-align: center;">Mechanism of Injury</p> <input type="checkbox"/> Use of machinery, tools, or equipment <input type="checkbox"/> Recreational, playing sports <input type="checkbox"/> Foreign body (e.g. splinter) <input type="checkbox"/> Ingestion of poison <input type="checkbox"/> Near drowning <input type="checkbox"/> Assault (e.g. gunshot, domestic violence) <input type="checkbox"/> Sexual assault or rape <input type="checkbox"/> Carbon monoxide exposure <input type="checkbox"/> Hit by or against object <input type="checkbox"/> Bite/sting: <input type="checkbox"/> insect <input type="checkbox"/> snake <input type="checkbox"/> human <input type="checkbox"/> animal (report to local public health) <input type="checkbox"/> Burn: <input type="checkbox"/> thermal (e.g. fire) <input type="checkbox"/> chemical <input type="checkbox"/> Fall, slip, trip: <input type="checkbox"/> Same level <input type="checkbox"/> from height <input type="checkbox"/> Motor vehicle crash: <input type="checkbox"/> driver/occupant <input type="checkbox"/> pedestrian/bicyclist <input type="checkbox"/> Other _____	<p style="text-align: center;">Acute Illness/Symptoms</p> <input type="checkbox"/> Pain, specify if possible: <input type="checkbox"/> Chest pain <input type="checkbox"/> Ear pain <input type="checkbox"/> Muscle or joint pain <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Headache <input type="checkbox"/> Other _____	<p style="text-align: center;">Disposition and Record Tracking</p> <input type="checkbox"/> Treated by Red Cross <input type="checkbox"/> Not treated by Red Cross <input type="checkbox"/> Refused treatment <input type="checkbox"/> Other _____ <input type="checkbox"/> Referred: <input type="checkbox"/> Hospital / Clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physician <input type="checkbox"/> Self-care <input type="checkbox"/> Aggregate Morbidity Form Entry (list date for each visit reported) <input type="checkbox"/> Intake Tool completed (check when client is referred during registration)

The initial worker legibly prints name, signature, credentials, date and time. Print Name _____ Date _____
Signature _____ Time _____

Notes (At time of visit, sign each entry with a date/time, print name, signature, credentials, activity and position)

Legibly document initial visit and each follow-up visit. Use concise language and standard medical terms; include referral information, phone contacts, and/or services provided. Check appropriate complaints and add a dated note next to the complaint. Document each follow-up visit on the daily Aggregate Morbidity Report Form. Disaster Health Services manager/supervisor review each Client Health Record for completeness and legible signatures, before the record is forwarded to the disaster relief operation headquarters or a chapter.
