

**PATIENT DETAILS**

|                               |                      |                   |                      |
|-------------------------------|----------------------|-------------------|----------------------|
| Patient First Name            | <input type="text"/> | Patient Last Name | <input type="text"/> |
| D.O.B.                        | <input type="text"/> | Case Number       | <input type="text"/> |
| Location                      | <input type="text"/> | Ward & Ben Number | <input type="text"/> |
| Patient Hospital/Facility URN | <input type="text"/> |                   |                      |

**ASSESSMENT**

|                                        |                      |
|----------------------------------------|----------------------|
| Date of EOG Assessment                 | <input type="text"/> |
| Time of EOG Assessment                 | <input type="text"/> |
| Individuals Present for EOG Assessment | <input type="text"/> |

|                     |                      |
|---------------------|----------------------|
| Primary Complaint   | <input type="text"/> |
| Secondary Complaint | <input type="text"/> |

**ASSESSMENT / CLINICAL FINDINGS / EXAMINATION**

|                      |
|----------------------|
| <input type="text"/> |
|----------------------|

**VITAL SIGNS, AND PATIENT CONDITION**

|             |                      |              |                      |
|-------------|----------------------|--------------|----------------------|
| Vital Signs | <input type="text"/> | GCS          | <input type="text"/> |
| PR          | <input type="text"/> | RR           | <input type="text"/> |
| BP          | <input type="text"/> | SPo2         | <input type="text"/> |
| TEMP        | <input type="text"/> | o2 LPM / VIA | <input type="text"/> |

### PATHOLOGY

|       |  |           |  |
|-------|--|-----------|--|
| NA    |  | K+        |  |
| CH    |  | Urea      |  |
| Creat |  | BUN       |  |
| Hb    |  | Platelets |  |

### PATIENT ASSESSMENT

|                     |                                      |                                           |                                    |
|---------------------|--------------------------------------|-------------------------------------------|------------------------------------|
| Mobility Assessment | <input type="checkbox"/> Independent | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Dependent |
| Weight              |                                      | Girth                                     |                                    |

### EOG RISK SUMMARY

|                                                  |                              |                                   |                               |                                  |
|--------------------------------------------------|------------------------------|-----------------------------------|-------------------------------|----------------------------------|
| Patient Condition Risk                           | <input type="checkbox"/> Low | <input type="checkbox"/> Moderate | <input type="checkbox"/> High | <input type="checkbox"/> Extreme |
| Transport Risk                                   | <input type="checkbox"/> Low | <input type="checkbox"/> Moderate | <input type="checkbox"/> High | <input type="checkbox"/> Extreme |
| Likelihood of Patient Deterioration in Transport | <input type="checkbox"/> Low | <input type="checkbox"/> Moderate | <input type="checkbox"/> High | <input type="checkbox"/> Extreme |

### COMMENTS / RECOMENDATIONS

### RETRIEVAL TEAM

|             |            |
|-------------|------------|
| Clinician 1 | Name:      |
|             | Signature: |
| Clinician 2 | Name:      |
|             | Signature: |