**How to Triage at GSC**

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| **#1)** Greet the patient and confirm their identity by asking for both their name and date of birth. Using the search bar, enter the patient’s date of birth or name in order to pull up their patient chart.  Once you have found their chart and confirmed that it is theirs, click on “New Encounter (SOAP).” If prompted, select “Continue with in progress encounter.” | * Hola, me llamo \_\_\_\_\_\_\_\_\_\_\_\_\_ y yo soy un voluntario(a). * ¿Cómo se llama? ¿Cuál es su fecha de nacimiento? |
| **#2)** Scroll down to the “Vitals” flow sheet. Enter the patient’s height and weight after measurements.  Depending on the location, you will either take their height and weight at the beginning of triage (West Columbia) or a nurse will take their measurements while you search for their chart (Old Percival). Either you (West Columbia) or a nurse (Old Percival) will then proceed to take other vitals.  Enter the patient’s vitals including:   * **Height and Weight** * **Blood Pressure (BP)**   + Make sure that the patient is not talking and does not have their legs crossed - Ask the patient to relax   + If the BP is very different from the last recorded BP, consider retaking it on the other arm – Add this reading in a comment and indicate which arm was used   + Blood Pressure Readings     - Normal: Less than 120 / Less than 80     - HTN: 140 or Higher / 90 or Higher   + You cannot diagnose a Pt with HTN but if they ask what their reading means let them know if it is low, high, or normal and let them know that normal is 120 / 80 * **Heart Rate (HR)** * **Last Menstrual Period (LMP)**   + If the patient (Pt) reports that she no longer menstruates, ensure that the date of her LMP was entered during a previous encounter   + If it has not yet been entered then ask the date of her last period – If she does not remember then enter the date as 01/01 of the last year that she reports having menstruated and add a comment that Pt no longer menstruates (post-menopausal, hysterectomy, IUD, etc.)   After taking BP, look under "Summary” to see if **Hypertension Education (Procedure)** has been performed during this calendar year.   * If it has not been performed, then provide the Pt with a HTN education worksheet completed with their BP information and name. * If given the worksheet, write in the “Chief Complaint” section that HTN education was performed during triage | * Necesito tomar su altura y peso. * Necesito tomar su presión. Relajase por favor. * Descruza sus piernas durante este examen. * ¿Cuándo fue su última regla? * Su presión es \_\_\_ sobre \_\_\_\_. * Este es un poco bajo/alto. * Este documento tiene información sobre su presión. |
| **#3)** Scroll up to the “Chief Complaint” section and enter the patient’s reason for visiting the clinic today. Be sure to enter the patient’s chief complaint in an objective manner, using as many of the patient’s words as possible.  Using the **OLDCART** method is a great way to ask the patient about the history of their present illness:   * **O**nset – When did the problem start? * **L**ocation – Where is the problem happening in your body? Do the symptoms radiate to other body areas? * **D**uration – How long has the problem been happening? * **C**haracter – What is the problem like? Does it change with specific activities? How would you describe the symptoms – burning, sharp, stabbing, crushing, dull, etc.? * **A**ggravating Factors – What makes the problem worse? * **R**elieving Factors – What helps this problem? * **T**iming – Is the problem constant or intermittent?   Ask the Pt about any relevant **medical history** – history (hx) of diabetes, HTN, etc.  Ask the Pt if they are currently taking any **medications** (Over the Counter – OTC, and Prescription). If the Pt says yes ask them if they have brought their medication with them.   * If yes, then record the name and dosage from the bottle and record in the “Chief Complaint” that you have seen the bottles * If no, record this in the “Chief Complaint” and ask the patient to bring all medications to any future visits   If a Pt is here for **results**, check whether there are any uploaded attachments that fit the description (found at the bottom of the encounter). If so, attach to today's encounter. If no, make a note to have Lidia/Kathleen/administrator to call the lab. | * ¿Cuál es su motiva de consulta hoy? * ¿Desde cuándo lo tiene? * ¿Dónde le duele? * ¿Ha aumentado o disminuido el dolor? * ¿Es un dolor constante o viene y se va? * ¿Qué enfermedades o síntomas tiene, de que sepa usted? ¿Tiene diabetes, presión alta, etc.? * ¿Qué medicinas toma? * ¿Tiene sus botellas de medicina con usted hoy? |
| **#4)** Using the information determined from the Pt’s chief complaint, determine which **laboratory tests** will need to be performed.   * **Blood Glucose:** All new patients, all diabetic patients (every visit), and all GYN patients * **HbA1c**: All diabetic patients every 2 – 3 months and any non-diabetic patient with an elevated blood glucose reading * **Hemoglobin:** All GYN patients and any patient reporting symptoms of fatigue, dizziness, fainting, or heavy periods * **Urinalysis (UA):** All GYN patients and any patient reporting symptoms of burning with urination (dysuria), urinary hesitancy, urinary frequency, new-onset lower back pain, or any patient with glucose reading greater than 500 * **Pregnancy Test**: Requested by patient * **Temperature**: If the Pt presents with signs of an infectious process, assess, and enter their oral temperature   To enter the results of these tests, scroll to the “In-House Tests” section and enter the patient’s lab results:   * When entering results, you will be prompted to enter a provider – select “Other” and save * When entering glucose, include “\_\_\_\_hpp” as the unit – This is the number of hours the patient has been eating or drinking anything other than water * When entering urinalysis, for any value noted as “NEG” or “NORM” on the UA print-out, enter the value as “0” and the units as “NEG” or “NORM” as indicated | * Necesito tomar   + Su glucosa (azúcar de sangre)   + A1c (ah – un – se)   + Hemoglobina   + Análisis de orina   + La prueba de embarazo   + Temperatura * ¿Cuándo fue la última vez que comiste? |
| **#5)** Be sure to **save each section** as you go and to click “Save” in each section before moving onto the next. |  |