MATTAPAN COMMUNITY HEALTH CENTER

Nurse Triage Form

Date: _____ Arrival Time: _____

Patient Name: _____ DOB: _____

Parent/Guardian: _____ Phone: _____

MRN : _____

Reason For Triage:

- □ Vaginal or Penile symptoms **(CARES)**
- □ **Chest** pain or new pain **(SAMES DAY)**
- □ STI/STD testing/treatment **(CARES)**
- □ Pregnancy test or birth control
- □ Blood Pressure/ Blood sugar check
- □ Counselling **(family planning)**
- □ Medication administration or education
- □ Wound check/Dressing change
- □ Cough/Fever/Shortness of breath (**New symptoms/ SAME DAY appointment**)
- □ Immunization or titer request
- □ Urinary symptoms

Other: Provider details regarding visit need:

_____

Dedication request-Patient may leave after this is completed.

- Medication name: _____
- Medication is used for: _____
- Pharmacy: _____
- Last office visit/ or next office visit: _____
- Expedite request (Please **allow 24 hours for medication to be filled**)
- Only select if you do not have any medication available

Nurse Triage: _____ Action: _____

Note completed: _____