

The Adult and Pediatric Triage and Intake forms will consolidate into a single form for each workflow. These new forms will be renamed ED Triage and ED Intake where adult and pediatric documentation will flex based on the patient's age and sex.

## PowerForm Name Update

ED Triage Adult and ED Triage Peds Part 1 will be renamed **ED Triage**. The ED Intake Adult and ED Triage Peds Part 2, will be renamed **ED Intake**. These forms will populate as a task in ED LaunchPoint.

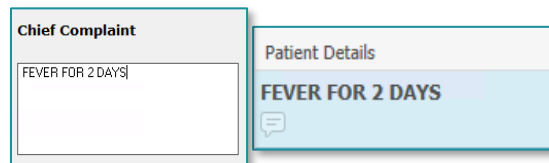
2	Assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ED Intake	03/06/26 14:54:29	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ED Triage	03/06/26 14:54:29	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## ED Triage

### ➤ ED Triage

- The ED Triage will open to the **Chief Complaint**.

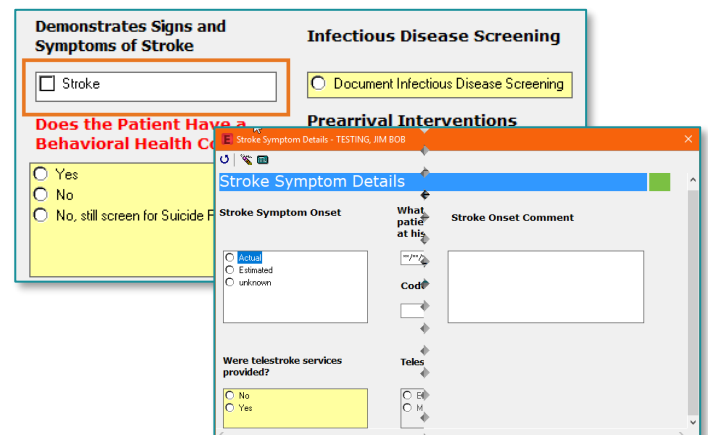
**NOTE:** Chief Complaint will appear within the ED LaunchPoint Patient Details field. Entering a patient problem will not appear within Patient Details.



- **Mode of Arrival** is a required field.

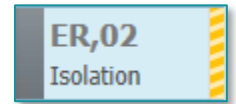
### ➤ Demonstrates Signs and Symptoms of Stroke

- If selecting **Stroke** within **Demonstrates Signs and Symptoms of Stroke**, a conditional response will open.
- Document the following if applicable:
  - Stroke Symptom Onset
  - Code Stroke Time Called
  - Telestroke Services Provided
  - Telestroke Service Location



**NOTE:** Selecting **Stroke** will trigger **Critical Care Code Stroke** within the ED Dashboard.

**NOTE:** To place a patient in an isolation precaution on ED LaunchPoint, document the isolation precaution within iView by navigating to ED Interventions View → Environmental Safety Management → Precautions Observed.



➤ **Infectious Disease Risk Screening**

- All risk factors and symptoms should be addressed with each patient. Follow appropriate protocols for your location based on the other risk factors and symptoms identified.

A rectangular form with a blue border. The title "Infectious Disease Screening" is at the top. Below it is a radio button followed by the text "Document Infectious Disease Screening".

➤ **Prearrival Interventions**

- Document clinical treatments performed prior to ED arrival.

A rectangular form with a blue border. The title "Prearrival Interventions" is at the top. Below it is a radio button followed by the text "Document pre-arrival interventions".

➤ **Triage Interventions**

- Triage Interventions can be documented prior to being seen by the provider.

➤ **Allergies**

- Allergies must be documented to provide drug interaction alerts while placing orders.

A rectangular form with a blue border. The title "Allergies" is at the top. Below it is a radio button followed by the text "Document".

Click [here](#) for more information on how to document allergies within PowerForms.

➤ **Fall Risk (Updated)**

- Fall Risk will flex depending on the age of the patient.
- **Kinder1** is used to quickly identify patients 18 and over at risk for falls in the Emergency Department.
- If an Adult patient meets the Kinder1 criterion, a patient is considered at risk for falls, and a Fall Risk icon appears on ED LaunchPoint.
- The **Humpty Dumpty Fall Risk** is an evidence-based tool to assess, score and prevent pediatric falls for patients 17 and under.

A rectangular form with a blue border. The title "Fall Risk" is at the top. Below it is a radio button followed by "Document Kinder Fall Risk". Below that is a radio button with "N/A" selected.A rectangular form with a blue border. The title "Fall Risk" is at the top. Below it is a radio button with "N/A" selected. Below that is a radio button followed by "Document Humpty Dumpty Fall Risk".

➤ **Documenting Behavioral Health Complaint**

- Nursing staff can screen patients for risk of suicide by using the CSSRS Screen. If further assessment is needed to identify the patient's immediate suicide risk level, the CSSRS Risk Assessment is completed.

A rectangular form with a blue border. The title "Does the Patient Have a Behavioral Health Complaint" is at the top in red. Below it are three radio buttons with the following options: "Yes", "No", and "No, still screen for Suicide Risk".

For more information on documenting the CSSRS Screen, click [here](#).

➤ **Postpartum and Pregnancy Status**

- Documentation of postpartum and pregnancy status is flexed by age and sex.
- This screening accommodates risk for postpartum preeclampsia.

A screenshot of a form section for pregnancy status. It includes a dropdown for 'Is patient up to 12 weeks Postpartum?' with options 'Yes', 'No', and 'N/A'. To the right, there are radio buttons for 'Pregnancy Status' with options 'Not pregnant', 'Possible pregnancy', and 'Currently pregnant'. Further right is a date field for 'First Day of LMP' and a text field for 'Approximate LMP'.

➤ **Vitals Signs and Measurements (Updated)**

- Vital signs have been relabeled by location name first.
- For patients ages 15 and younger, *measured* height and weight are required.
- This is a requirement due to providers relying on growth charts to evaluate children and adolescent growth patterns and discrepancies for possible underlying concerns.

A screenshot of a form section for temperature measurements. It features three input fields labeled 'Oral Temperature', 'Temporal Temperature', and 'Rectal Temperature', each with a 'DegC' unit indicator.

A screenshot of a 'Measurements' form. It has a blue header and a red note: 'For all patients 15 or younger, MEASURED height/length is required'. Below this, there are fields for 'Weight Dosing in Kg', 'Weight Method', 'Height' (with a unit dropdown showing 'cm' and a conversion to '5 ft 9 Inch'), 'Height Method', 'BMI', and 'Ideal Body Weight'.

➤ **Pain Assessment (Updated)**

- Document if the patient has **Actual** or suspected pain.
- If **Yes** is selected, answer **Yes** or **No** if the patient is **Able to Self Report Pain**.

A screenshot of a 'Pain Present' form. It has two main sections: 'Pain Present' with radio buttons for 'No actual or suspected pain' and 'Yes actual or suspected pain', and 'Able to Self Report Pain?' with radio buttons for 'Yes' and 'No'. There is also a label for 'Primary Pain Location'.

➤ **Patient Acuity**

- Document the patient's Tracking Acuity by clicking the dropdown and selecting the acuity for the patient's presented problem.

A screenshot of a 'Patient Acuity' form. It includes a 'Tracking Acuity' dropdown menu and an 'Emergency Service Index' section with a radio button for 'Document'.

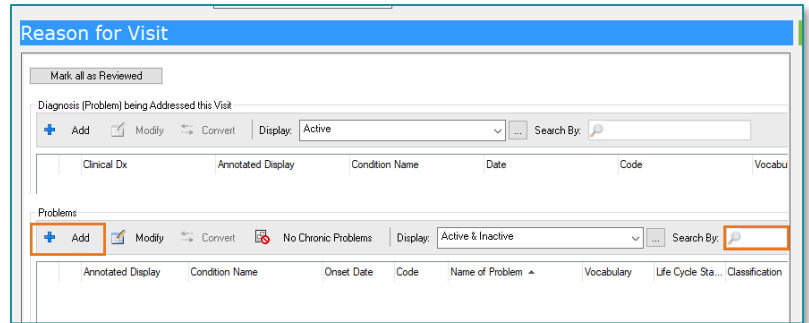
**NOTE:** If unable to determine the acuity, the ESI (Emergency Service Index) can be used to determine acuity.

➤ Reason for Visit

- Document the patient's chief complaint within the Problems section by clicking **Add** or by using the **Search By** option.

**NOTE:** Do not add problems through **Diagnosis**. This is used by ED providers at time of discharge.

**NOTE:** If there are required fields in the ED Triage form incomplete upon signing, the task will not complete in Activities.

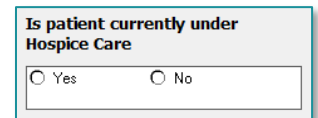


**ED Intake**

➤ Document Reason Unable to obtain Current Visit information, if applicable.

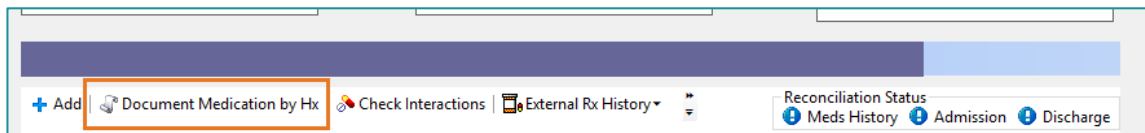
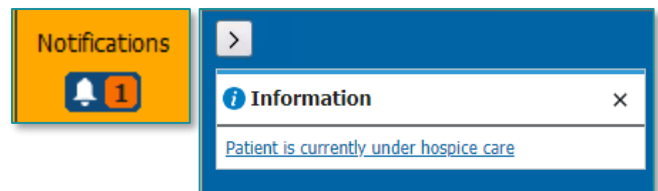
➤ Is patient currently under Hospice care? (Updated)

- Previously located on Triage.
- If **yes** is selected, a SmartZone alert will notify nursing and providers the patient is currently under Hospice Care.



➤ Home Medications

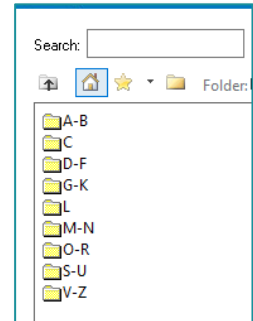
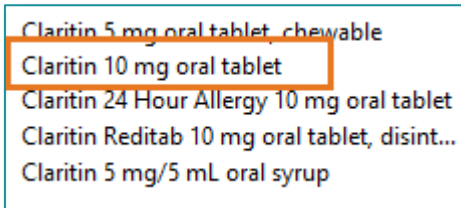
- Medication history and compliance is required for every ED encounter.
- Click document to **Document Medications by Hx**.



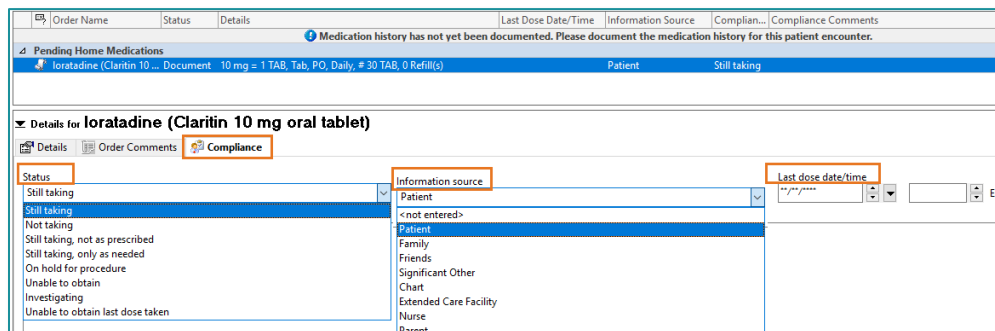
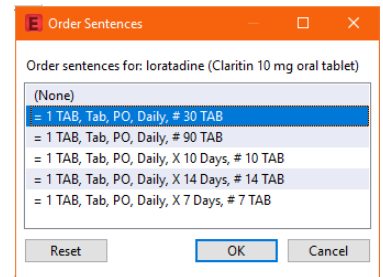
- Click **+Add** to add a new Home Medication that has not been documented.



- Use the **Folders** to search for the medication.
  - Alternatively, the **Search** option is available.
- Select the medication closest to what the patient is prescribed.

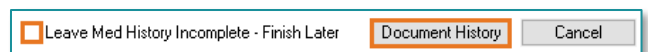


- Choose the order sentence, then click OK.
- If other Home Medications need to be added, continue to search for the medications on the remaining open screen. If not, click **Done** to close.
- To document **Compliance**, click the Compliance tab.
  - Complete the **Status**, **Information Source** and **Last dose date/time** for each home medication.



- Click **Document History** when completed.
- If **unable** to complete Medication History, click **Leave Med History Incomplete – Finish Later**.

➤ **Procedure History**



- Update patient's procedure history as needed.

➤ **Social History**

- For more information on Social History documentation, click [here](#).

➤ Social Determinants (Updated)

- Social Determinants of Health (Prapare) Form must be answered **once annually**.
- To help ED nursing with identifying the last time the Social Determinants was documented, the **last documented date** will be pulled forward within the **Last Social Determinants Update**.
- ED's are required to ask patients if they would like help with any positive barriers identified.
  - This question was previously omitted from ED encounters.

Social Determinants  
 Open social determinants documentation  
 Open SDoH Opt-Out screening  
**Last Social Determinants Update**  
SDoH Recommendation Satisfied: Yes (12/30/2025)

**NOTE:** If a patient indicates a Yes, the Care Management team will contact the patient and resources will be provided based on their need.

Would the patient like help with any POSITIVE barriers identified today? (If no barriers are identified, select No)  
 No  Yes

**NOTE:** If "No qualifying data available." appears, the form must be updated.

**Last Social Determinants Update**  
No qualifying data available.

➤ What Matters (Updated)

- What Matters is documented for patients age 65 and older.
- The goal of documenting **What Matters** is to understand and align care with the older adult's specific health outcome goals, care preferences, and gives the patient the opportunity to share their fears and concerns.
- For more information on documenting What Matters, click [here](#).

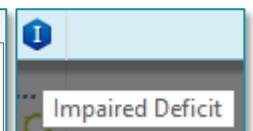
**What Matters**  
 Document What Matters

➤ Communication Needs/Preferences (Updated)

- **Sensory Deficits (Updated)**
  - Patients identified with sensory deficits will have an **Impaired Deficit icon** displayed in the Patient Information column on ED LaunchPoint to alert staff.

**Communication Needs/Preferences**  
 Document Communication Needs/Preferences

Sensory Deficits  
 Blind, left eye  
 Blind, right eye  
 Hearing deficit, left ear  
 Hearing deficit, right ear  
 Nonverbal  
 Sensation/Touch deficit  
 Speech deficit  
 Uncorrected visual impairment  
 Other:



➤ **Last Tetanus (Updated)**

- Last Tetanus status can be accessed within the ED Intake if the patient previously received the immunization within NLH.

Last Tetanus	Last Tetanus Dose via NLH
<input type="radio"/> Unknown <input type="radio"/> Less than 5yrs <input type="radio"/> Less than 10yrs <input type="radio"/> Greater than 10yrs <input type="radio"/> Not applicable	tetanus/diphth/pertuss (Tdap) adult/adol: 0 Unknown Unit (09/12/2024)

➤ **Animal Control Notified (Updated)**

- Now opens the **Mandatory and Allowable Disclosures** form.
- For more information about the Mandatory and Allowable Disclosures form, click [here](#).

Animal Control Notified
<input type="radio"/> Yes <input type="radio"/> No

**NOTE:** If any required fields in the ED Intake form are left incomplete when the form is signed, the task will not complete in Activities.