McLaren Medical Group

Telephone Triage Router

Priority Status: ☐ Routine ☐ STAT	Patient Name:
Date/Time:	Patient DOB:
Caller Name:	Patient Allergies:
Relationship to patient:	Primary Physician:
Telephone Number:	

Is this due to auto injury or workers' compensation? ☐ Yes ☐ No

☐ **PAIN**

Type of Pain?

- ☐ Chest
- ☐ Abdominal
- ☐ Musculoskeletal
- ☐ Injury – explain

Location of Pain?

Severity of pain (1-10 scale)?

Onset of Pain – when did it start?

☐ Today ☐ Within the past week

☐ Two weeks ago or longer

Is pain radiating? ☐ Yes ☐ No

If yes, where is it radiating?

☐ **Skin injury / laceration / wound** Date of occurrence: _____

location: _____

bleeding / drainage: ☐ No ☐ Yes: give details

☐ **Other Symptoms** Date of onset: _____

Headache: ☐ Congestion: ☐ Wheezing: ☐ Cough: ☐

Fever: ☐ Sore Throat: ☐ Difficulty Breathing/SOB: ☐ Rash: ☐

☐ **Other:** Describe, give details

Operator Signature: _____ Time: _____

ADVICE GIVEN TO PATIENT/TREATMENT PLAN

Call Returned By:	Date/Time Call Returned:
☐ Patient understands advice/treatment plan	Provider's Signature/Date