

Flu Triage and Symptoms Form

Date: _____ Name: _____ Age: _____ DOB: _____ Chart#: _____

Date of onset of symptoms: _____ Clinical Support Staff: _____
(name)

Contact with patient: Phone triage On site visit

Chronic Health Conditions: _____

Have you recently traveled to an affected area? Yes No

Have you had direct contact with pigs? Yes No

Have you had close contact with a sick person? Yes No

Have you experienced an occupational risk of exposure (please specify below)? Yes No

Agriculture Healthcare Laboratory

Check all that apply:

Fever:

- < 100.4 (38°C) By report _____ Actual reading _____
- ≥ 100.4 (38°C) By report _____ Actual reading _____
- c/o chills

Sore throat (if yes): Is the patient able to swallow solids and/or liquids? Yes No

Headache (if yes): Use pain scale 1 – 10 to determine severity of pain.

Patient Response: _____

Level of Activity:

Alert and responsive
Tired and weak
Extremely exhausted
Lethargic/ slow to respond or react

Cough:

Mild
Often
Constant
Productive
Non-productive
Discomfort with coughing

Breathing Pattern:

Dyspnea (discomfort with breathing)
Labored
Noise or wheezing sounds
Chest retractions
Nasal Flaring
No. of respirations/minute: _____

Check All that Apply:

Sneezing Runny Nose Dizziness Muscle Aches Nausea Vomiting Diarrhea

Comments:

Plan:

Home Care Instructions
Office Visit Scheduled _____
(date) (time)
Referred to Local Hospital _____
(name)