The goals of the triage process is to gather sufficient data for determining acuity, identify immediate needs, and establish a rapport with the patient and family. The assessment process must be rapid and systematic utilizing age-specific considerations. The triage process should be completed in less than five minutes.

1. Major threats to the airway, breathing, and circulation will be assessed and the nurse will provide immediate interventions for identified threats and/or transport the patient to the appropriate treatment area.
2. When no immediate threat is identified, the nurse will elicit the chief complaint.
3. The triage nurse will focus his/her investigation on the history of the complaint.
4. The history of the present illness/injury will be determining onset, duration, provoking/alliavating factors, mechanism of injury and accompanied signs and symptoms. If pain is the chief complaint; severity (pain scale), quality and radiation of the pain will also be ascertained.
5. History will be obtained from EMS personnel, police, family or witnesses if available in the unconscious/unresponsive patient.
6. A focused physical assessment will be performed depending on the chief complaint.
   Mental status, skin temperature, moisture and color of mucous membranes will be assessed in addition to the focused physical exam. (See appendix)
7. A past medical, surgical, psychiatric and family history will be ascertained.
8. Last menstrual period for women of child bearing age
9. Immunization history and allergies.
10. Current weight for patients <18 years of age.
11. Current medications and dosages including OTC and herbal/natural remedies will be documented
12. Treatment prior to triage.
13. Vital signs will be recorded as appropriate including pulse oximetry and pain scale.
15. All patients are assessed for abuse/neglect. (domestic violence, child abuse/neglect, elder abuse/neglect and sexual assault)
Guidelines for the focused physical assessment:

Upon completion of the chief complaint and history of present illness/ injury the triage nurse will perform a focused physical exam in addition to mental status, skin and mucous membrane assessment. Examples of complaints are provided.

1. Cardiopulmonary: breath sounds, peripheral edema, peripheral pulses Examples; chest pain, shortness of breath, dyspnea on exertion, weakness, lightheadedness.
2. Neurological: pupil size and reactivity, speech quality, facial symmetry, motor strength and equality and Glasgow coma scale, fingerstick. Examples; change in mental status, seizure, headache, dizziness, difficulty in walking, speaking or moving, head or neck trauma.
3. Abdominal/pelvis: inspection, palpation, guarding, rebound, referred pain, rigidity CVA tenderness, pulsatile masses, breath sounds, last meal, last bowel movement. Examples: abdominal pain, nausea, vomiting, diarrhea, abnormal bowel movements, constipation, difficulty or pain on urination, hematuria, vaginal bleeding, trauma.
6. Trauma/wound evaluation depends upon mechanism of injury. Major trauma may require head to toe exam.
7. Ear or throat: hearing loss, oral cavity edema, edema to lips. Examples; ear pain, throat pain, pain on swallowing, difficulty in swallowing, foreign body.
8. Opthomological: visual acuity, sclera color, conjunctiva color, pupil equality and reactivity, ocular movements. Examples; eye pain, vision loss, vision abnormalities, foreign body, trauma.
9. Skin: color, description of rash, urticaria, lice, scabies, wounds (lacerations, contusions, avulsions, skin tears) Examples; pain, itching, rash bumps on skin.
10. Obstetrical: fetal heart rate, crowning. Examples; water broke, in labor, abdominal pain, vaginal bleeding, baby is not moving, trauma.