REFERENCE CARD FOR WHO EMERGENCY UNIT FORM: GENERAL

DATES/TIMES: Do not leave dates/times blank. Where unknown, write UNK

MASS CASUALTY: Check box if patient part of a mass casualty event

AGE: If age unknown, circle category: IN (infant) if appears <1 year of age, CH (child) if 1-18 years, or AD (adult)

OCCUPATION: Be as specific as possible (eg. farm laborer or farm manager instead of farming)

PATIENT RESIDENCE: Note if homeless, migrant worker, other

CHIEF COMPLAINT: Always in the patient's own words

DEAD ON ARRIVAL: Use ONLY if NO signs of life on arrival

NORMAL VITAL SIGNS – FOR ALL: SpO_2 >92% on RA, Temp 36˚C - 38˚C

Paediatric:

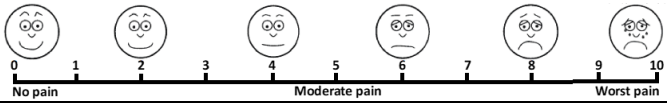
AGE	RESPIRATORY RATE
<2 months	40-60 breaths per minutes
2-11 months	25-50 breaths per minute
1-5 years	20-40 breaths per minute

AGE	PULSE RATE RANGE
0-1	100-160
1-3	90-150
3-6	80-140

*Record O_2 saturation and amount/route of O_2, eg. 94% on 2L by NC

Adult: Pulse 60-100 bpm, RR 10-20, SPB >90

Pain score: Ask the patient to choose the face that best represents the pain they are experiencing.



TREATING PROVIDER ASSESSMENT Date and time of first assessment of patient by medical provider at current facility

Primary Survey

Airway: *Normal (NML)*
•Patent (speaking normally)
•NO signs of obstruction, stridor or angioedema

•OPA/NPA=oro-/naso-pharyngeal airway •LMA=laryngeal mask airway •BVM=bag valve mask •ETT=endotracheal tube
•TTP=tenderness to palpation

Breathing: *NML*
• Effort normal
• Sounds clear

Abnormal
•Distant breath sounds •Crepitation •Rhonchi •Wheezing • Enter N/A for spontaneous RR if sedated, paralyzed or on ventilator

•NC=nasal cannula •NRB=non-rebreather mask •BVM=bag valve mask •CPAP/BiPAP=continuous or bi-level positive airway pressure
•Ventilator=mechanical ventilation

Circulation: *NML*
•Warm & dry
•Pulse strong & symmetric (upper & lower extremities)

Abnormal
•JVD (jugular venous distention)
•Prolonged capillary refill (>3 sec)

Access: Document location (loc) and size
•IV=peripheral intravenous •CVL=central venous line
•IO=intraosseous
•IVF (intravenous fluids): •NS=normal saline) •LR=Lactated Ringer's •Other (write name)

Disability: *NML*
•Alert (A) •Oriented to person/place/time
•Moves all extremities

Abnormal
•Responds only to Verbal (V), Pain (P), or is Unconscious (U)
•Motor or sensory deficit (note location)

•Pupil Size: normal, large, or pinpoint
•Pupil Reactivity: Reactive (NML/brisk), slow, fixed, nonreactive (NR)

•Blood glucose (RBG): Normal >3.5 mmol/L
•Antiepileptic (eg. diazepam, phenytoin, etc.)
•Others: list (eg. sedation medications for agitation, antihypertensives for hypertensive emergency, etc.)

REVIEW OF SYSTEMS (*If patients do not have any of these symptoms, mark NML)*

General: Fever, chills, night sweats, fatigue, weight loss
Head/Ears/Eyes/Nose/Throat (HEENT): Vision changes, discharge (eye/ear), pain (eye/ear), nose bleeds, mucosal lesions, difficulty swallowing, drooling, sore throat, dental problem, facial swelling
Respiratory: Difficulty breathing, cough, sputum production, bloody sputum, wheezing
Cardiovascular (CV): Chest pain, chest tightness, palpitations, orthopnea, edema
Gastrointestinal (GI): Anorexia, abdominal pain, nausea, vomiting, vomiting blood, diarrhea, blood in stool, black/tarry stool
Genitourinary: Urination (difficulty, pain, frequency, blood), incontinence, flank pain, genital lesions

Female Reproductive: Vaginal bleeding, vaginal discharge, abnormal menses, pelvic pain
If pregnant – Decreased fetal movement, contractions, leakage of fluid
Male Reproductive: Penile discharge, testicular pain, penile pain, priapism
Skin: Rash, itching, jaundice, ulcers
Musculoskeletal (MSK): Myalgia, joint pain/swelling
Hematologic (Heme): Lymphadenopathy, easy bruising
Neurologic (Neuro): Headache, syncope, focal weakness, numbness, dizziness, lightheadedness, speech problems, balance problems
Psychiatric: Hallucination, agitation, homicidal thoughts, suicidal thoughts, depression, anxiety
Pediatric specific: Unable to feed, decreased activity, decreased urine, vomiting everything, convulsions, excessive irritability

NOTE:** if more than one calendar is used in your setting by clinical providers and recorded as such on this form, all dates must be converted to Gregorian calendar and times converted to 24-hour format by data clerk before it is entered into registry.

MEDICAL HISTORY

Past Medical History
•DM •COPD •HTN •Psych •Renal disease •Other (list conditions not noted, eg. heart disease, stroke, asthma, sickle cell, active cancer, HIV/AIDS)
Medication: include anticoagulants, rx medications, traditional medicines, herbs and supplements

Immunization: Ask if up to date. Review card if available.
Safe at home: Ask about violence in the home

Family History
•Early death
•Known heart disease
•Cancer
•Epilepsy

Normal Exam (Check NML only if NO abnormal findings as below are present)

General: Well-developed, well-nourished, awake, alert
Neuro/Psychiatric: Oriented X3, CN intact, no focal weakness or sensory deficits**.** Nml mood and affect, nml behavior, nml thought content
HEENT: Normocephalic, atraumatic. Eyes **-** Pupils equal and reactive, extra ocular movements intact, conjunctivae normal
Neck: Trachea midline, neck supple, ROM nml
Cardiac: Nml rate and rhythm, strong pulses, nml sounds

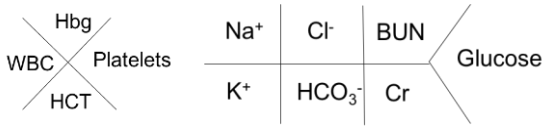
Respiratory: Nml effort, nml breath sounds
Abdominal: Soft and non-tender, bowel sounds nml
Pelvis/GU/Rectal: External genitals nml, no costovertebral angle (CVA) tenderness
MSK: Range of motion nml
Skin: Warm, intact, capillary refill ≤3 sec
Lymph: No lymphadenopathy

Abnormal Exam Findings (Always specify right or left when needed to clarify abnormal finding)

General: Distressed, malnourished (if suspect obtain MUAC), diaphoretic, uncooperative, sedated, lethargic
Neuro/Psychiatric: Neuro **-** Disoriented, CN deficit, focal sensory or motor deficit, abnormal gait or coordination, tremors, seizure activity, Kernig/Brudzinski sign, abnormal rectal tone. Psych- Suicidal, depressed, homicidal, delusional, agitated, hallucinating, abnormal speech
HEENT: Dry mucus membranes, tonsillar exudate, abnormal fontanelle, ear discharge, oral lesions, facial swelling. Eyes - Conjunctiva pale, peri-orbital lesion, abnormal ocular movements, scleral jaundice, eye discharge, pupils unequal and/or slow or non-reactive
Neck: Neck stiffness, JVD, carotid bruit, neck mass, tracheal deviation
Cardiac: Distant heart sounds, systolic or diastolic murmur, S3 or S4 gallop, friction rub, irregular pulse

Respiratory: Absent breath sounds, decreased breath sounds, crackles, wheezes
Abdominal: Distension, tenderness, rebound, guarding, ascites, hepatomegaly, splenomegaly, mass
Pelvis/GU/Rectal: Penile discharge, testicular mass or tenderness, CVA tenderness**,** vaginal bleeding or discharge, cervical motion tenderness, adnexal tenderness, blood or dark stool on rectal exam
If pregnant - No fetal heart rate
MSK: Joint swelling, decreased ROM or strength, scoliosis, kyphosis, spine tenderness
Skin: Rash, lesion, ulcer, pustules, bruising, petechiae, poor turgor, capillary refill > 3 seconds
Lymph: Adenopathy (head, cervical, supraclavicular, axillary or inguinal), lymphedema

DIAGNOSTICS



UPT: Urine pregnancy test
ECG: Electrocardiogram
Other: List study name (eg. lactate, amylase, lipase, PT/INR, PTT, CK, CK MB, cultures [blood, CSF or urine]) and result
Imaging: Specify type (XR, CT, U/S), location and results. *If study needed but not available, write this in other.*

INTERVENTIONS (if no interventions, write NONE)
Fluids/Medications: list Blood product type (eg. PRBC, platelets) and number of units, write medication name/dose in appropriate category if applicable (eg. Opioid Analgesia: Morphine 4 mg)
•Other: Vasopressors, post-intubation gtt, etc.
Procedures: list number of attempts, location, and outcome for each procedure, if applicable
•Other: Diagnostic peritoneal lavage, regional block, central line placement (if not noted in "Circulation" section), suprapubic catheterization, cricothyroidotomy, foreign body removal, etc.

ASSESSMENT AND PLAN (include summary and differential diagnosis AND plan for imaging, pain meds, consults)

CONSULT Document service, name, time of call AND time of arrival with any recommendations

REASSESSMENT: Time, vitals and clinical condition

DISPOSITION Write date and time of ED departure, updated vital signs (VS), check box for destination
Checklist Completion: Use WHO medical emergency checklist to verify tasks have been completed

DIAGNOSIS: List all diagnoses

Admit or Transfer: Write the name of the accepting provider for all handovers.

Discharge: Confirm that plan including follow-up care was discussed with the patient.

Death: Specify cause of death, but DO NOT WRITE cardiac or respiratory failure/arrest. Instead, use precise terms such as "pneumonia" or "organophosphate poisoning" or "suicide."

Document all providers engaged in the patient's care including through shift handovers.

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