**Sample #2**

**IBD Nurse Triage**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long has it been going on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IBD Dx : \_\_\_ UC \_\_\_ Crohn’s Date Diagnosed: \_\_\_\_\_\_\_\_\_\_

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| **Simple Clinical Colitis Activity Index (UC)** |
| DaytimeBowel Frequency | 0 = 1-31 = 4-62 = 7-93 = >9 |
| NighttimeBowel Frequency | 1 = 1-32 = 4-6 |
| Urgency of defecation | 1 = Hurry2 = Immediately3 = Incontinence |
| Blood in Stool | 1 = Trace2 = Occasionally Frank 3 = Usually Frank |
| General Well-Being | 0 = Very well1 = Slightly below par2 = Poor3 = Very poor4 = Terrible |
| Extracolonic Features | 1 per manifestation |
| **Total Score** |  |
| **<2.5 indicates remission****Higher score indicates more active disease** |

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| **Partial Harvey Bradshaw Index (Crohn’s)** |
| General Well-Being | 0= Very Well1= Slightly below par2= Poor3= Very poor 4= Terrible |
| Abdominal Pain | 0= None1= Mild2= Moderate3= Severe |
| Number of liquid stools per day | 0= No liquid stools1= 1-2 liquid stools2= 3-4 liquid stools3= 5-6 liquid stools4= 7-8 liquid stools5=>8 liquid stools  |
| **Total Score** |   |
| **<3 indicates remission****Higher score indicates more active disease** |

**Blood in stool?** \_\_\_ Hematochezia \_\_\_ Melena **Nausea?** YES/NO **Vomiting?** YES/NO How often? \_\_\_\_

**Fever?** YES/NO Highest Temp \_\_\_\_\_\_\_\_\_ **Recent labs/ x-ray?** YES/NO Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications for IBD:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent Change in Medications?** YES/NO Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Provider Notified:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommendations:** \_\_\_ ER \_\_\_ Appointment Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Changes?** YES/NO Specify if yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provided reassurance and clarification of current treatment?** YES/NO

Nurse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_