**Sample #2**

**IBD Nurse Triage**

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

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

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

|  |  |
| --- | --- |
| **Simple Clinical Colitis Activity Index (UC)** | |
| Daytime Bowel Frequency | 0 = 1-3 1 = 4-6 2 = 7-9 3 = >9 |
| Nighttime Bowel Frequency | 1 = 1-3 2 = 4-6 |
| Urgency of defecation | 1 = Hurry 2 = Immediately 3 = Incontinence |
| Blood in Stool | 1 = Trace 2 = Occasionally Frank  3 = Usually Frank |
| General Well-Being | 0 = Very well 1 = Slightly below par 2 = Poor 3 = Very poor 4 = Terrible |
| Extracolonic Features | 1 per manifestation |
| **Total Score** |  |
| **<2.5 indicates remission**  **Higher score indicates more active disease** | |

|  |  |
| --- | --- |
| **Partial Harvey Bradshaw Index (Crohn’s)** | |
| General Well-Being | 0= Very Well 1= Slightly below par 2= Poor 3= Very poor  4= Terrible |
| Abdominal Pain | 0= None 1= Mild 2= Moderate 3= Severe |
| Number of liquid stools per day | 0= No liquid stools 1= 1-2 liquid stools 2= 3-4 liquid stools 3= 5-6 liquid stools 4= 7-8 liquid stools 5=>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\_\_\_\_\_\_\_\_\_\_\_\_\_\_