PATIENT OBSERVATION RECORD
EMERGENCY CENTER OBSERVATION UNIT
WILLIAM BEAUMONT HOSPITAL - ROYAL OAK

PRIVATE PHYSICIAN - ***TIME CONTACTED*** -

REASON FOR OBSERVATION - (EC Obs Unit DX)

VITAL SIGNS (CIRCLE) - PER ROUTINE Q _____HOUR

ACTIVITY (CIRCLE) - AD LIB / BRP / BEDREST / WITH ASSISTANCE

RESPIRATORY - O2:

DIET (CIRCLE) - REGULAR / CARDIAC / _____cal ADA / _____gm SODIUM /_____LIQUID

TMS (CIRCLE) - NO / YES (PATIENTS ON TMS MAY BE TRANSPORTED TO EC OBS UNIT WITHOUT AN RN)

EC OBSERVATION PLAN OF CARE:

- ESTIMATED LENGTH OF STAY (GOAL=3-18 HRS): _____
- RE-EVALUATE FOR DISCHARGE: _____

SENDING ECP SIGNATURE & ID#:_____

*****DICTATION MUST BE COMPLETE BEFORE TRANSFER TO Observation Unit****

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INJECTION SITE CODES

A - LEFT DORSOGLUTEAL	B - RIGHT DORSOGLUTEAL
C - LEFT VENTROGLUTEAL	D - RIGHT VENTROGLUTEAL
E - LEFT THIGH	F - RIGHT THIGH
G - LEFT ARM	H - RIGHT ARM
I - LEFT ABDOMEN	J - RIGHT ABDOMEN

PHYSICIANS ORDER SHEET - EC OBSERVATION UNIT

ATTENTION PHYSICIAN: This preprinted form is available to facilitate patient care.
Order items by checking the box in front of the item and / or completing the blanks where necessary.
If additional items are needed, add them on the standard Doctors Order sheet (Form 280).

REASON FOR OBSERVATION : / EC OBSERVATION PLAN OF CARE

1. Initial Obs Unit ECP : Time Contacted :
2. Private Physician : Time Contacted :
3. • Print ECP Dictation ASAP
4. Allergies:
5. • Vital Signs per Routine
6. Activity : ☐ BRP ☐ Other _____
7. Respiratory : ☐ O2 per guidelines
8. Diet : ☐ Regular ☐ Cardiac ☐ _____ cal ADA
   ☐ _____gm NA ☐ _____ liquid
9. TMS : ☐ NO ☐ YES (Patients on TMS may be transported to EC Obs unit without an RN)
10. ☐ Home medications - transcribe onto med sheet. ECP to review and order
11. CPR Status Order : ☐ Full CPR (Call CPR Team)
    ☐ No CPR (CPR team will not be called, no chest compressions will be initiated by unit staff in the event of cardiopulmonary arrest)

_____ Page No. _____
Attending Physician Signature

MEDICATION ORDERS AND ADMINISTRATION RECORD

	Date	Date
12. ☐ IV 0.9NS @ _____ ml/hr **OR**	0000 1200	0000 1200
☐ Heparin Lock	0000 1200	0000 1200
13. ☐ Prochlorperazine (Compazine) 5 mg IV Push Q 6h PRN nausea **OR**	0000 1200	0000 1200
☐ Trimethobenzamide (Tigan) 200 mg IM Q 6h PRN nausea	0000 1200	0000 1200
14. ☐ Acetaminophen (Tylenol) 975 mg PO Q 6h PRN pain or fever (maximum 4gm/24hrs)	0000 1200	0000 1200
15. ☐ Ibuprofen (Motrin) 600 mg PO Q 6h PRN pain or fever	0000 1200	0000 1200
16. ☐ Maalox 30cc PO PRN indigestion	0000 1200	0000 1200
17. ☐ Temazepam (Restoril)15 mg PO QHS PRN sleep	0000 1200	0000 1200

Sending ECP Signature	Dr. Page No.	Date	Time	Name & ID #	Name & ID #

Noted by Unit Secretary	Date	Time	Noted by R.N.	Date	Time		

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PATIENT ID STAMP

EC OBSERVATION UNIT CHEST PAIN TRACKING SHEET

	Time 0 = triage time (ECG, CKMB, Myo)*	4 hours (ECG, CKMB, Myo)	4hr – 0hr ** CKMB / Myo diff.	8 hours – *if needed* (CK, TnT, ECG)***
Time				
ECG				
CK (M<230, F<150)				
CK-MB (< 10ng/ml)				
CK-MB index (< 4.0%)				
Myoglobin (< 110ng/ml)				
Troponin T (<0.2ng/ml)				

*** If** 4 hour labs are sent, **call lab** to add Myoglobin to initial EC blood.
******4hr – 0hr diff. = Myoglobin and CKMB change over 4 hours = Time 0 hr (EC) – 4 hr level
******* 8 hour testing indicated if: **(a) 4 hr test missed, (b) any Myoglobin elevated,**
(c) Myoglobin or CKMB are NORMAL but DOUBLES over 4 hours.

4 HOUR ECG: _____

Stress test (circle one): TIME DONE _____

GXT / GXT-MPI / PERSANTINE / GXT-Echo / Dobut.-Echo / NONE

Stress test results (circle one):

NORMAL / ABNORMAL / EQUIVOCAL - INDETERMINANT

FINAL Observation Unit diagnosis (circle one):

- MI
- Unstable angina
- Musculoskeletal chest pain
- Gastritis – esophagitis
- Anxiety disorder
- Other (write in) _____

NOT A PERMANENT PART OF THE MEDICAL RECORD

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EC OBSERVATION UNIT NURSING AND PHYSICIAN ASSESSMENT SHEET

Chief Complaint :

HPI (O,P,Q,R,S,T, Details) -

Past Medical History :

- ☐ Yes ☐ No Diabetes (Insulin Dependent DM / Non Insulin Dependent DM)
- ☐ Yes ☐ No High Cholesterol or Lipids
- ☐ Yes ☐ No Hypertension (High Blood Pressure)
- ☐ Yes ☐ No Heart Problems (Angina / Heart Attack(MI) / Bypass Surgery / Angioplasty / Valve Disease)
- ☐ Yes ☐ No Lung Problems (Asthma / Emphysema / COPD)
- ☐ Yes ☐ No Kidney Problems (Kidney Stones / Kidney Failure / Kidney Infections)
- ☐ Yes ☐ No Seizure (Epilepsy)
- ☐ Yes ☐ No Stroke / TIA
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Other Problems _____

Past Surgical History (Operation, Year)

Allergies (Drug, Reaction)

Medications - Please record in the space below any Medications, the **dose**, and **how often** you take it.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Family History - Do you have any illnesses or diseases that run in your immediate family as noted below?

- ☐ Yes ☐ No Family history of heart attack / angina
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Hypertension
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Other disease (Please specify) _____

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EC OBSERVATION UNIT NURSING AND PHYSICIAN ASSESSMENT SHEET

Social History:

☐ Yes ☐ No Do you smoke?
If so, how many packs a day? _____
How many years have you smoked? _____

☐ Yes ☐ No Do you drink alcohol?
If so, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

☐ Yes ☐ No Do you use any illegal drugs?

Review of Systems : Have you had any problems related to the following areas?

☐ Yes ☐ No Recent weight loss or weight gain
Weight _____ Height _____

☐ Yes ☐ No Fevers, chills, night sweats

☐ Yes ☐ No Eye problems, vision problems

☐ Yes ☐ No Sore throat, difficulty swallowing

☐ Yes ☐ No Jaw pain, teeth pain, cavities

☐ Yes ☐ No Neck pain, neck swelling

☐ Yes ☐ No Chest pain, heart palpitations, heart pain, chest aching, chest discomfort or pressure

☐ Yes ☐ No Difficulty breathing, short of breath, frequent cough, or cough up blood

☐ Yes ☐ No Abdominal pain, foods upset your stomach

☐ Yes ☐ No Frequent vomiting or vomiting blood

☐ Yes ☐ No Diarrhea, constipation, black stools

☐ Yes ☐ No Pain with urinating, urinating often

☐ Yes ☐ No Testicular pain or swelling

☐ Yes ☐ No Menstrual problems, vaginal discharge
Date of last menstrual period _____

☐ Yes ☐ No Muscle pains, joint pain or swelling

☐ Yes ☐ No Nervous problems, psychiatric problems

☐ Yes ☐ No Allergies, skin rashes

☐ Yes ☐ No Blood disorder, clotting problems, easy bruising

☐ Yes ☐ No Headaches, confusion, slurred speech, weak, numb or paralyzed limb

☐ Yes ☐ No Dizziness, difficulty walking

☐ Yes ☐ No Back pain, back injury

☐ Yes ☐ No Deafness, ringing in ears, buzzing in ears

☐ Yes ☐ No Sleepiness, difficulty arousing

Nurse Signature _____

Reviewing ECP Signature _____