American Red Cross

Client Health Record | CONFIDENTIAL

DRO # _____ **DRO Name** _____ **DRO Date** _____ **Case #** _____

Service Delivery Site _____ **City/County/State** _____ **CAS #** _____

Client Information

Name (Last, First) _____ **Primary Language** _____

Age _____ **Date of Birth** _____ ☐ Male ☐ Female ☐ Other **Veteran** ☐ Yes ☐ No

Pre-Disaster Address _____

Current Address _____ **Phone #** _____

Alternate Contact Name _____ **Phone #** _____

Caregiver: ☐ Home Health Provider ☐ Parent ☐ Spouse ☐ Friend ☐ None ☐ Other _____

Name _____ **Phone #** _____

Allergies

List all medication, environmental and food allergies, and include type of reaction.

_____

_____

_____

Insurance Information and Medical History

Policyholder Name _____ **Policy Phone #** _____ **Policy #** _____

Health Care Provider _____ **Provider Phone #** _____

Treatment & Release Date _____ **Hospitalized** ☐ Yes ☐ No **Where** _____

Medical History _____

_____

_____

_____

_____

_____

Current Medication	Dosage	Last Dose	Current Medication	Dosage	Last Dose

Pharmacy Name _____ **Phone #** _____

Psy START Mental Health Triage

Risk factors identified by Disaster Health Services and Disaster Mental Health. Do not ask the client about these risk factors directly. These risk factors should be identified during client interaction.

***** *Contact site manager and DMH immediately or call 911*

****** *Contact DMH as soon as possible and document referral*

***** *Contact DMH at end of shift and document referral on the Client Health Record*

☐ ***Danger to self or others	☐ **Trapped or delayed evacuation
☐ **Felt/expressed extreme panic or fear	☐ **Family member currently missing or unaccounted for
☐ **Felt direct threat to life of self and/or of family member	☐ **Unaccompanied child
☐ **Saw/heard death or serious injury of other	☐ *Home not livable
☐ **Death of parent, child or family member	☐ *Separated from immediate family during event
☐ **Death of pet	☐ *Prior history of mental health care
☐ **Significant disaster-related illness or physical injury to self or family member	☐ No triage risk factors identified

Primary complaints and notes continued on page 2

Client Name (Last, First) _____ **Case #** _____ **CAS #** _____

Primary Complaints

Check all complaints that apply to the current visit under each category related to the patient's main reason(s) for seeking care. Do not record client's medical history in this area. For follow-up visits, enter the date next to the box to update the notes section.

Date of Injury _____

Type of Injury

- ☐ **Abrasion, cut, laceration**
- ☐ **Avulsion, amputation**
- ☐ **Concussion**
- ☐ **Bruise, contusion**
- ☐ **Fracture**
- ☐ **Sprain, strain**
- ☐ **Other** _____

Mechanism of Injury

- ☐ **Use of machinery, tools, or equipment**
- ☐ **Recreational, playing sports**
- ☐ **Foreign body** (e.g. splinter)
- ☐ **Ingestion of poison**
- ☐ **Near drowning**
- ☐ **Assault** (e.g. gunshot, domestic violence)
- ☐ **Sexual assault or rape**
- ☐ **Carbon monoxide exposure**
- ☐ **Hit by or against object**
- ☐ **Bite/sting:**
  - ☐ insect
  - ☐ snake
  - ☐ human
  - ☐ animal (report to local public health)
- ☐ **Burn:**
  - ☐ thermal (e.g. fire)
  - ☐ chemical
- ☐ **Fall, slip, trip:**
  - ☐ Same level
  - ☐ from height
- ☐ **Motor vehicle crash:**
  - ☐ driver/occupant
  - ☐ pedestrian/bicyclist
- ☐ **Other** _____

Acute Illness/Symptoms

- ☐ **Pain,** *specify if possible*:
  - ☐ Chest pain
  - ☐ Ear pain
  - ☐ Muscle or joint pain
  - ☐ Abdominal pain
  - ☐ Headache
  - ☐ Other _____

Acute Illness/Symptoms (Cont'd)

- ☐ **Cardiac event**
- ☐ **Fever (>100.4°F or 38°C)**
- ☐ **Heat related illness symptoms**
- ☐ **Cold-related condition symptoms**
- ☐ **Extreme fatigue or overexertion**
- ☐ **Eye irritation**
- ☐ **Dehydration symptoms**
- ☐ **Gastrointestinal:**
  - ☐ Nausea or vomiting
  - ☐ Diarrhea (bloody or watery)
- ☐ **Respiratory:**
  - ☐ Shortness of breath or difficulty breathing
  - ☐ Chest congestion
  - ☐ Congestion, runny nose, sinusitis
  - ☐ Sore throat
  - ☐ Wheezing in chest
  - ☐ Cough
- ☐ **Influenza-like-illness (ILI)** (fever of 100.4°F or 38° C or greater AND cough and/or sore throat)
- ☐ **Skin:**
  - ☐ Generalized rash
  - ☐ Localized rash
  - ☐ Soft tissue infection
  - ☐ Fungus, ring worm, tinea
- ☐ **Obstetrics/Gynecology:**
  - ☐ Vaginal bleeding outside of pregnancy
  - ☐ Pregnancy - abdominal cramping
  - ☐ Vaginal discharge
  - ☐ Pregnancy complications
- ☐ **Neurological**, *specify*: _____
- ☐ **Mental Health:**
  - ☐ Behavior:
  - ☐ Depressed mood
  - ☐ Anxiety or stress
  - ☐ Disruptive
  - ☐ Agitated
  - ☐ Suicidal or homicidal thoughts
  - ☐ Psychotic symptoms (e.g. hallucinations, paranoia)
  - ☐ Drug/alcohol intoxication / withdrawal
- ☐ **Not specified elsewhere**, *specify*: _____

Care

- ☐ **Blood pressure check**
- ☐ **Dressing change / wound care**
- ☐ **Medication refill**
- ☐ **Blood sugar check**
- ☐ **Immunization / vaccination**
- ☐ **Pregnancy / post-partum assessment**
- ☐ **Other** _____

Exacerbation of Chronic Illness

ONLY if current visit related. Do not record patient HX.

- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Cancer**, *specify* _____
- ☐ **Renal disease / dialysis**
- ☐ **Seizure disorder**
- ☐ **Hypertension**
- ☐ **Congestive heart failure**
- ☐ **Coronary heart disease (e.g. MI)**
- ☐ **Cerebrovascular disease / stroke**
- ☐ **Chronic joint pain (e.g. arthritis)**
- ☐ **Obstructive pulmonary disease**
- ☐ **Previous Mental health diagnosis,** *specify*:

  _____
- ☐ **Other** _____

Disposition and Record Tracking

- ☐ **Treated by Red Cross**
- ☐ **Not treated by Red Cross**
- ☐ **Refused treatment**
- ☐ **Other** _____

  _____
- ☐ **Referred:**
  - ☐ Hospital / Clinic
  - ☐ Pharmacy
  - ☐ Physician
  - ☐ Self-care
- ☐ **Aggregate Morbidity Form Entry** (list date for each visit reported)

  _____
- ☐ **Intake Tool completed** (check when client is referred during registration)

The initial worker legibly prints name, signature, credentials, date and time.

Print Name _____ **Date** _____

Signature _____ **Time** _____

Notes (At time of visit, sign each entry with a date/time, print name, signature, credentials, activity and position)

Legibly document initial visit and each follow-up visit. Use concise language and standard medical terms; include referral information, phone contacts, and/or services provided. Check appropriate complaints and add a dated note next to the complaint. Document each follow-up visit on the daily Aggregate Morbidity Report Form. Disaster Health Services manager/supervisor review each Client Health Record for completeness and legible signatures, before the record is forwarded to the disaster relief operation headquarters or a chapter.

Notes continued on page 3

Client Name (Last, First) _____ **Case #** _____ **CAS #** _____

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