

24 Hour Triage Rapid Assessment and Access Toolkit for Children and Young People V2 (2020) Log Sheet

Hospital name and department:

Patient details	Patient history	Enquiry details
Name:	Diagnosis (Inc. other diagnoses / co-morbidities):	Date: Call start time:
NHS no:		Who is calling?
Hospital no:		
DoB:	Male ☐ Female ☐	What phone number do you want us to call back on?
Age:	Consultant team:	Reason for the call (in caller's own words):
Phone no:		

What treatment is the patient receiving? (Please tick below)

Chemotherapy (incl. oral maintenance) ☐ Immunotherapy ☐ Car-T ☐ Radiotherapy ☐ Post Stem Cell Transplant ☐ Surgery ☐ None ☐

When did the patient last receive treatment?:

What is the patient's temperature?: °C ***please note** that hypothermia is a significant indicator of sepsis*

When was the patient last discharged / reviewed? Have you called any other healthcare professional in the last 48 hours? Yes* ☐ No ☐

Does the patient have a central line? Yes ☐ N ☐ Does the patient have a shunt / Ommayer Reservoir / other medical device? Yes ☐ N ☐

Advise ● Follow up/review ● Assess ●
REMEMBER two or more amber = RED

Please document current medication

Please document significant medical history:
(Include last FBC if known and date taken, and **detail of any recent calls*)

Fever	● ● ●
Infection	● ● ●
Shortness of breath / difficulty breathing	● ● ●
Bleeding and / or bruising	● ● ●
Neurosensory / Neuromotor	● ● ●
Activity	● ● ●
Pain	● ● ●
Rash and / or infectious disease contacts	● ● ●
Nausea, eating, drinking	● ● ●
Vomiting	● ● ●
Mucositis	● ● ●
Urinary output	● ● ●
Diarrhoea	● ● ●
Constipation	● ● ●
Other (please state)	● ● ●

Action taken / advice given:

Attending for assessment at:

Receiving team notified: Yes ☐ N ☐
 Call end time:

Triage practitioner details

Signature:

Designation:

Print name:

Date:

Review of actions taken: (Review no later than 24 hours after call. Single Ambers require earlier call back)

Signature:

Designation:

Print name:

Date:

Hospital logo:



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in CHILDHOOD
CANCER

