

VTAC CORK: TRIAGE AND DISCHARGE FORM

VIRTUAL TRAUMA ASSESSMENT CLINIC CORK



(please affix patients label here)

Date of Triage: __/__/____

Facilitator: _____
(Nurse/Physiotherapist)

Referral source: CUH MUCC Mercy Mallow Bantry

Other _____

X-RAY: AVAILABLE NOT AVAILABLE

Date of injury: __/__/____

Date of ED presentation: __/__/____

Diagnosis:

Treatment Plan:

Discharge with information Referral to OT Inappropriate referral
Referral to physio Referral to #clinic (PTO) *reason:* _____

Weight bearing status: NWB PWB WBAT FWB

Period of time to avoid work? _____ Driving? _____ Contact sports? _____

Record of Telephone Call Confirm patient I.D Confirm side

Date __/__/____ Time _____ | Date __/__/____ Time _____ | Date __/__/____ Time _____

Name of Parent/Legal Guardian receiving the phone call: _____

Is patient comfortable in boot/brace/splint/sling/backslab that has been applied? YES NO

Has patient got normal feeling/movement of fingers/toes on the injured side? YES NO

Is pain relief adequate? YES NO

Is skin broken over the injured area? Any unusual smell/odour from cast? N/A YES NO

Was range of movement Function Swelling discussed? YES NO

Have risk of DVT/PE been discussed? N/A YES NO

Bone health – osteoporosis/smoker/diabetes? YES NO

HAS PATIENT BEEN GIVEN THE CONTACT DETAILS FOR VTAC CLINIC? YES NO

Any other concerns?

Has letter been dictated to GP YES NO

Has letter/ discharge advice been sent to Patient/Guardian YES NO

Signed: _____ Date: _____

VTAC CORK: Onward referral to Fracture Clinic



(please affix patients label here)

Date of Triage: __/__/____

Facilitator: _____
(Nurse/Physiotherapist)

Referral source: CUH MUCC Mercy Mallow Bantry

Other _____

X-RAY: AVAILABLE NOT AVAILABLE

Date of ED presentation: __/__/__

Date of injury: __/__/__

Diagnosis:

Fracture Clinic Management Plan:

Weight bearing status: NWB PWB WBAT FWB

Period of time to avoid work? _____ Driving? _____ Contact sports? _____

Book for specific Consultant _____ Book for _____ weeks

X-ray on arrival Yes / No (*please circle and fill in appropriately*)

If Yes:

- Type of x-ray: _____

- In/Out of backslab: _____

- In new cast: _____

- Other: _____

If No:

- For Clinical assessment on arrival:

Other:

Has letter been dictated to GP YES NO

Signed: _____ Date: _____