Methodist Hospital

Rapid Evaluation Team (RET) Call Record

216306PNCVS

NAME:

DOB:

MR#: HCL# :

LABEL or ADDRESSOGRAPH

Date	Room #	Attending/Primary MD	Time notified
Time called	Arrival time	End time	Code status

Reason for RET call *(circle all that apply)*

LOC/Neuro change	Respiratory status change	HR change	BP change	Pain	Fluid status	Staff concern
↓ LOC	<12 >28	<40 >130	SBP <90 >170	New	I>O wet lung	Color/Appearance
Confused	SOB	Rhythm:	Undetectable	Recurring	UOP <50cc/4hrs	Glucose <50 >400
Seizure	O2 sat:			Location:		Other:

Situation/Assessment

History ☐ CHF ☐ COPD ☐ Recent surgery:
☐ HTN ☐ DM ☐ Other:

Interventions

☐ EKG	☐ Nebulizer	☐ Start telemetry	☐ Narcan/Romazicon
☐ ABGs	☐ Bipap	☐ Atropine	☐ Lasix
☐ Lab work	☐ Intubation	☐ Drug to ↓ HR	☐ Give narcotic
_____	☐ Code ► ☐ 68 ☐ 99	_____	_____
☐ Radiology	☐ Give anxiolytic	☐ Vasoactive drip	☐ Give fluid bolus
_____	_____	_____	_____

☐ Other interventions/recommendations:

RN signature _____

Patient Outcome ☐ Stayed on floor ☐ Transfer to _____ If Code called ► ☐ Survived ☐ Expired

_____ **was updated post-RET visit by** _____ **at** _____
Attending/Primary MD Staff member Time

This information is used for Quality Assessment purposes and is confidential and privileged information protected under Minnesota Statute 145.61-145.67.

NAME:

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2-4 hour follow-up

Rapid Evaluation Team RN _____ Date _____ Time _____

12-15 hour follow-up

Rapid Evaluation Team RN _____ Date _____ Time _____