

Triage Risk Screening Tool (TRST)

Instructions: Please make a check mark in the appropriate box to indicate **presence or suspicion of any of the following**

*** Please complete for all patients 75+ years of age***

1. History of cognitive impairment (poor recall or not oriented)
2. Difficulty walking / transferring or recent falls
3. Five or more medications
4. ED use in previous 30 days or hospitalization in previous 90 days
5. Lives alone **and/or** no available caregiver
6. ED staff professional recommendations:

<input type="checkbox"/> Nutrition / weight loss	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Failure to cope	<input type="checkbox"/> Medication issues
<input type="checkbox"/> Sensory deficits	<input type="checkbox"/> Depression / low mood
<input type="checkbox"/> Other _____	

If 2 or more factors identified: Referral to GEM Nurse Referral to GEM Nurse **not** indicated
 Referral to Social Work when GEM nurse not available

Name / Signature: _____ Date (d/m/y): _____

Time: _____

Date GEM assessed: _____ Time GEM assessed: _____

For Office Use Only:

GEM Disposition: Home CCAC Admitted
 LTC Other _____

Please return to Jane Jennings Emergency Department.