

The following document is a overview and training outline for those people doing assessment and history taking in Station 2 (Triage) for Occupy Medical Triage. All individuals doing assessment and history taking without supervision by a lead OM triage person must have demonstrated their proficiency in all of the topics covered in this overview. In addition they will be expected to have been oriented to Occupy Medical and have read the Occupy Medical Policies and Procedures. No person is authorized or will act outside of their scope of practice while volunteering at Occupy Medical or in the Triage Station.

Vision:

Health care is a human right.

Mission:

Our primary concern is delivering excellent, timely, and appropriate medical care in a variety of settings for the betterment of the community health.

We additionally provide health-related outreach, empowerment, and education in the context of the greater Occupy movement.

Overview of the Triage Station

The Triage process is divided into three main parts:

- 1. Initial meeting of the patient. Scene size-up**
- 2. History taking**
- 3. Assessment and initial exam**

Note: The number of steps and the order in which the steps in a patient assessment are performed depends on the patient's condition. Each patient is different.

Initial Meeting of the Patient Scene Size-up

1. Be aware of scenes that have the potential for violence.
 - a. Violent patients**
 - b. Distraught family members**
 - c. Angry bystanders**
2. Be aware of the patients condition. If they potentially have a communicable disease standard precautions and personal protective equipment (PPE) need to be considered. Should you be wearing gloves or a mask? Should the patient be in the bus where they may expose others? Have you washed your hands after the last patient?
3. Standard precautions are protective measures that have traditionally been developed by the Centers for Disease Control and Prevention for use in dealing with:
 - a. Objects**
 - b. Blood**
 - c. Body fluids**
 - d. Other potential exposure risks of communicable disease**
4. The concept of standard precautions assumes that all blood, body fluids (except sweat), non-intact skin, and mucous membranes may pose a substantial risk of infection.

Form a general impression.

1. The initial general impression begins to be formed the minute you meet the patient.
2. The impressions includes making a note of the person's:

a. Age	f. How to they walk?
b. Sex	g. Are they having difficulty breathing?
e. Overall appearance	h. Are they agitated or lethargic?
d. Level of distress	
e. Level of responsiveness	

3. As you approach, make sure the patient sees you coming.
 - a. **Introduce yourself.**
 - b. **Address the patient by name.**
 - c. **Explain whom you are and what you are going to be doing over the next few minutes.**
 - d. **Make sure the patient is ok if there is an observer or another patient being triaged at the same time.**

History Taking

1. History taking first establishes the patients Chief Complaint and then provides detail about the patient and an account of the patient's signs and symptoms.
2. Be sure to document the following information:
 - a. **Past medical history that may be appropriate to why the patient is being seen**
 - b. **All results of assessments and interventions**
 - c. **Patient's current health status**
3. Investigate the chief complaint (history of present illness).
 - a. **To investigate the chief complaint, begin by making introductions, make the patient feel comfortable, and obtain permission to treat.**
 - i. **Ask a few simple, open-ended questions.**
 - ii. **Refer to the patient by using the patient's name.**
 - iii. **Use eye contact, body position, and language to show you care, and encourage the patient to continue speaking.**
4. Obtain SAMPLE history.
 - a. **Symptoms cannot be felt or observed by others.**
 - b. **Signs are objective conditions that can be seen, heard, felt, smelled, or measured by you or others.**
 - c. **Use the mnemonic SAMPLE to obtain the following information:**
 - i. **Signs and symptoms**—What signs and symptoms occurred at the onset? What's going on? Why did you come here today?

- ii. **Allergies**—Is the patient allergic to any medication, food, or other substances? If no, enter **NKA**, No Known Allergies.
 - iii. **Medications**—What medications is the patient taking? Drugs or Alcohol?
 - iv. **Pertinent past medical history**—Does the patient have any medical history that might be relevant to why they are being seen today? Have they seen a doctor about this in the past? Have they been self-treating?
 - vi. **Last oral intake**—it may be pertinent to ask when did the patient last eat or drink?
 - vii. **Events leading up to injury or illness**—It may be pertinent to determine what events led to this incident?
5. Use the OPQRST mnemonic to assess pain.
- a. **Onset**—When did the problem begin and what caused it?
 - b. **Provocation or palliation**—Does anything make it feel better or worse?
 - c. **Quality**—What is the pain like?
 - d. **Region/radiation**—Where does it hurt? Can they describe the pain?
 - e. **Severity**—On a scale of 1 to 10, how would you rate your pain?
 - f. **Timing**—Has the pain been constant or does it come and go? How long have they had it?
6. Identify pertinent negatives.
- a. **Pertinent negatives are negative findings that warrant no care or intervention but may be helpful in ruling out some possibilities.**
7. Taking history on sensitive topics

Only when the patient's chief complaint or their symptoms indicate, will you gather information about sexual history or violence. Alcohol and drug use may be very important in developing an accurate diagnosis and should be inquired about during the SAMPLE history.

- a. **Alcohol and drugs:**
 - i. **Signs may be confusing, hidden, or disguised.**
 - ii. **Many patients may deny having any problems.**
 - iii. **The history gathered from a chemically dependent patient may be unreliable.**
 - iv. **Do not judge the patient, and be professional in your approach.**
 - v. **Explain that it may be important to know if we are going to be prescribing other medications and need to avoid possible interactions.**
- b. **Physical abuse or violence**
 - i. **Report all physical abuse or domestic violence to the appropriate authorities.**
 - ii. **Follow local protocols.**
 - iii. **Do not accuse; instead, immediately involve law enforcement.**

We are mandatory reporters. If you suspect abuse, report your concerns to the doctor or to Sue.

8. Sexual history

Male Triage persons should exercise caution when talking about sexual history with a child or women. It may be appropriate to ask another person to be present during the exam. It may be helpful to have a mental health person present.

- a. **Consider all female patients of childbearing age who report lower abdominal pain to be pregnant unless ruled out by history or other information.**
- b. **Questions to ask:**

- i. **When was your last menstrual period?**
 - ii. **Are your periods normal?**
 - iii. **Do you have urinary frequency or burning?**
 - iv. **What is the severity of cramping, and are there any foul odors?**
 - v. **Is there a possibility you may be pregnant?**
 - vi. **Are you taking birth control pills?**
 - vii. **How many sexual partners do you have?**
- c. Inquire about urinary symptoms with male patients.**
- i. **Is there pain associated with urination?**
 - ii. **Do you have any discharge, sores, or an increase in urination?**
 - iii. **Do you have burning or difficulty voiding?**
 - iv. **Has there been any trauma?**
 - v. **Have you had recent sexual encounters?**
- d. Ask about the potential for sexually transmitted diseases in all patients.**

Special challenges in obtaining patient history include:

1. **Silence**
 - a. **Patience is extremely important when dealing with patients and their emergency crises.**
 - b. **Using a close-ended question that requires a simple yes or no answer may work best.**
 - c. **Consider whether the silence is a clue to the patient's chief complaint.**
2. **Overly talkative**
 - a. **Gathering details about a patient's medical condition may be difficult if he or she talks around your question or you have a difficult time refocusing the patient's conversation.**
 - b. **Reasons why a patient may be overly talkative:**
 - i. **Excessive caffeine consumption**
 - ii. **Nervousness**
 - iii. **Ingestion of drugs**
3. **Multiple symptoms**
 - a. **Expect multiple symptoms in the geriatric age group.**
 - b. **Prioritize the patient's complaints, start with the most serious and end with the least serious.**
 - c. **Explain that the patient may be seen for only the most serious complaints and asked to return at a later day to address less serious concerns.**
4. **Anxiety**
 - a. **Frequently patients may be anxious about seeing a doctor. You can expect anxious patients to show signs or symptoms such as:**
 - i. **Pallor**
 - ii. **Diaphoresis**
 - iii. **Shortness of breath**
 - iv. **Rapid heart rate**
 - v. **Dizziness or light-headedness**

vi. Increase in blood pressure

If you encounter these type of signs of symptoms, don't hesitate to ask the patient if they are nervous, if they are, reassure them.

Ask a mental health person to sit in with you to help reassure the patient.

5. Anger and hostility

- a. **Be aware of the potential for unexpected violence or hostility.**
- b. **Remain calm, reassuring, and gentle.**
- c. **If the scene is not safe or secured, seek additional assistance immediately; know the "Safe Word" for HELP. Ask a mental health person to sit in with you to help reassure the patient.**

6. Intoxication- do we treat intoxicated patients, if so, on the bus?

- a. **Do not put an intoxicated patient in a position where he or she feels threatened and has no way out.**
 - i. **The potential for violence and a physical confrontation is high when a patient is intoxicated.**
- b. **Alcohol dulls a patient's senses, which will make it difficult for an intoxicated patient to inform you that something feels painful.**
- c. **If the scene is not safe or secured, seek additional assistance immediately; know the "Safe Word" for HELP. Ask a mental health person to sit in with you to help reassure the patient.**

7. Crying

- a. **A patient who cries may be sad, in pain, or emotionally overwhelmed.**
- b. **Remain calm and be patient, reassuring, and confident, and maintain a soft voice.**
Ask a mental health person to sit in with you to help reassure the patient.

8. Depression

- a. **Depression is among the leading causes of disability worldwide.**
- b. **Symptoms include:**
 - i. **Sadness**
 - ii. **A feeling of hopelessness**
 - iii. **Restlessness**
 - iv. **Irritability**
 - v. **Sleeping and eating disorders**
 - vi. **A decreased energy level**
- c. **The most effective treatment in handling a patient's depression is being a good listener.**
Ask a mental health person to sit in with you to help reassure the patient.

9. Confusing behavior or history

- a. **Conditions such as hypoxia, stroke, diabetes, trauma, medication use, and other drug use could alter a patient's explanation of events.**
 - i. **Hypoxia is the most common cause of confusion.**
- b. **In geriatric patients, it is not uncommon to encounter a patient who has dementia, delirium, or Alzheimer disease.**

10. Limited cognitive abilities

- a. **These patients are considered developmentally challenged.**
- b. **Keep your questions simple, and limit the use of medical terms.**
- c. **In cases of patients with severely limited cognitive function, rely on the presence of family, caregivers, and friends to supply answers to your questions.**

11. Language barriers

- a. **Find an interpreter, if possible.**
- b. **If not, determine whether the patient understands who you are.**
- c. **Keep questions straightforward and brief, and use hand gestures.**
- d. **Be aware of the language diversity in your community.**

12. Hearing problems

- a. **Ask questions slowly and clearly.**
- b. **Use a stethoscope to function as a hearing aid for the patient.**
- c. **Learning simple sign language during your career will help in the communication process.**
- d. **Use a pencil and paper.**

13. Visual impairments

- a. **Identify yourself verbally when entering the scene.**
- b. **It is important that you put any items that have been moved back into their previous position.**
- c. **During the assessment and history-taking process, explain to the patient what is happening.**

Patient Assessment and initial physical exam

Patient assessment began when you first greeted your patient.

1. The goal of the patient assessment is to identify and initiate the treatment process, which may entail recommending a doctor, mental health worker, an herbalist or the pharmacy see the patient. Triage's role is not to diagnose the patient, it is to gather information that may be helpful for a doctor to make an accurate diagnosis.
 2. The patient's vital signs and history will help determine where you will recommend the patient should be seen next
 3. Assess vital signs using the appropriate monitoring devices which may include; sphygmomanometer, stethoscope, thermometer and when appropriate glucose monitor.
 - a. **These devices should never be used to replace your comprehensive assessment of your patient.**
 - b. **Think of these devices as adjuncts to the assessment of your patient.**
- A. Assess level of consciousness (LOC).
1. The LOC is considered a vital sign.
 - a. **Tells a lot about a patient's neurologic and physiologic status**
 2. Determine which of the following categories best fits your patient:
 - a. **Conscious with an unaltered LOC**
 - b. **Conscious with an altered LOC**
 3. Conscious with an altered LOC may be due to inadequate perfusion.
 - a. **Perfusion is the circulation of blood within an organ or tissue.**

b. Can also be caused by medications, drugs, alcohol, or poisoning

B. Assess circulation (Pulse) see the table at the end of the document for normal ranges of pulse

1. Circulation is evaluated by assessing the pulse rate, pulse quality, and pulse rhythm.
2. Assess pulse.
 - a. **Often referred to as a heartbeat, the pulse is the pressure wave that occurs as each heartbeat causes a surge in the blood circulating through the arteries.**
 - b. **To determine if a pulse is present, you will need to palpate (feel) the pulse.**
 - i. **In responsive patients who are older than 1 year, you should palpate the radial pulse at the wrist.**
 - iii. **Palpate the brachial pulse, located at the medial area (inside) of the upper arm, in children younger than 1 year.**

(a.) Pulse rate

- i. **For an adult, the normal resting pulse rate should be between 60 and 100 beats/min and could be as much as 100 beats/min in geriatric patients.**
- ii. **In pediatric patients, generally the younger the patient, the faster the pulse rate.**
- iii. **To obtain the pulse rate in most patients, you should count the number of pulses felt in a 30-second period and then multiply by two.**
- iv. **A rate that is greater than 100 beats/min is described as tachycardia.**
- v. **A rate of less than 60 beats/min is described as bradycardia.**

(b.) Pulse quality

- i. **If the pulse feels of normal strength, you should describe it as being strong.**
- ii. **You should describe a stronger than normal pulse as “bounding.”**
- iii. **A pulse that is weak and difficult to feel is described as “weak” or “thready.”**

(c.) Pulse rhythm

- i. **Determine whether the rhythm is regular or irregular.**
- ii. **When the interval between each ventricular contraction of the heart is short, the pulse is rapid.**
- iii. **When the interval is longer, the pulse is slower.**
- iv. **The pulse should be easy to feel; weak pulses may signal problems.**

C. Assess breathing (Respiration) see the table at the end of the document for normal ranges of respirations.

1. Breathing is a continuous process in which each breath regularly follows the last with no notable interruption. A normal adult breathes 12 to 20 times per minute or once every 4 to 5 seconds.
 - a. **You will assess breathing by:**
 - i. **Watching the patient’s chest rise and fall**
 - ii. **Listening for unusual breath sounds**
 - iii. **Looking for signs of respiratory distress**
 - iv. **Look for retractions**
2. When assessing breathing, obtain the following information:
 - a. **Respiratory rate**
 - b. **Rhythm—regular or irregular**

- c. **Quality/character of breathing**
- d. **Depth of breathing**
- 4. **Ask yourself the following questions:**
 - a. **Does the patient appear to be choking?**
 - b. **Is the respiratory rate too fast or too slow?**
 - c. **Are the patient's respirations shallow, deep or very rapid?**
 - d. **Is the patient cyanotic (blue)?**
 - e. **Do I hear abnormal sounds?**
 - i. **Is the breathing noisy breathing, such as snoring, bubbling, gurgling, crowing?**
- 3. **Respiratory rate**
 - a. **A normal respiratory rate varies widely in adults, ranging from 12 to 20 breaths/min.**
 - b. **Children breathe at even faster rates.**
 - c. **Respirations are determined by counting the number of breaths in a 30-second period and multiplying by two.**
 - i. **The result equals the number of breaths per minute.**
 - d. **While counting the patient's respirations, also note the rhythm.**
 - i. **If the time from one peak chest rise to the next is fairly consistent, respirations are considered regular.**
 - ii. **If respirations vary or change frequently, they are considered irregular.**
- 4. **Quality of breathing**
 - b. **Normal breathing is silent or, in a very quiet environment, accompanied only by the sounds of air movement at the mouth and nose.**
 - c. **A patient who coughs up thick, yellowish or greenish sputum (matter from the lungs) most likely has an advanced respiratory infection.**
- 5. **Depth of breathing**
 - a. **The amount of air that the patient is exchanging depends on the rate and the tidal volume.**
 - i. **Tidal volume is a measure of the depth of breathing and is the amount of air in milliliters that is moved into or out of the lungs during one breath.**
 - b. **Shallow respirations can be identified by little movement of the chest wall (reduced tidal volume) or poor chest excursion.**
 - i. **Deep respirations cause a significant rise and fall of the chest.**
 - c. **The presence of retractions (indentation above the clavicles and in the spaces between the ribs) or the use of accessory muscles of respiration is a sign of inadequate breathing.**
 - i. **Nasal flaring and seesaw breathing in pediatric patients indicate inadequate breathing.**
 - ii. **A patient who can speak only two or three words without pausing to take a breath, a condition known as two- to three-word dyspnea, has a serious breathing problem.**
 - d. **Normal breathing is an effortless process that does not affect a patient's speech, posture, or positioning.**
 - i. **In the tripod position, a patient is sitting and leaning forward on outstretched arms with the head and chin thrust slightly forward; significant conscious effort is required for breathing.**

- ii. In the sniffing position, the patient sits upright with the head and chin thrust slightly forward, and the patient appears to be sniffing.
- e. Breathing that becomes progressively more difficult requires progressively more effort; this is known as labored breathing.

D. **Assess skin (SCTM)** Normal skin is Pink, warm and dry

- a. A normally functioning circulatory system perfuses the skin with oxygenated blood.
 - i. Perfusion is assessed by evaluating a patient's skin color, temperature, moisture, and capillary refill.
- b. **Skin color**
 - i. The skin's color is determined by the blood circulating through vessels and the amount and type of pigment that is present in the skin.
 - ii. Poor peripheral circulation will cause the skin to appear pale, white, ashen, or gray.
 - iii. When the blood is not properly saturated with oxygen, it appears bluish.
 - iv. High blood pressure may cause the skin to be abnormally flushed and red.
 - v. Changes in skin color may also result from chronic illness.
- c. **Skin temperature**
 - i. Normal skin temperature will be warm to the touch (normal body temperature is 98.6°F).
 - ii. Abnormal skin temperatures are hot, cool, cold, and clammy.
- d. **Skin moisture**
 - i. Dry skin is normal.
 - ii. Skin that is wet, moist (often called diaphoretic), or excessively dry and hot suggests a problem.
- e. **Capillary refill**
 - i. Capillary refill is evaluated to assess the ability of the circulatory system to restore blood to the capillary system.
 - ii. To test capillary refill:
 - (a) Place your thumb on the patient's fingernail with your fingers on the underside of the patient's **finger and gently compress.**
 - (b). **Remove the pressure.**
 - (c). **As the underlying capillaries refill with blood, the nail bed will be restored to its normal pink color.**
 - (d). **With adequate perfusion, the color in the nail bed should be restored to its normal pink color within 2 seconds.**

E. **Blood pressure (BP) measurement** see the table at the end of the document for normal ranges of Blood Pressure

- a. The sphygmomanometer (blood pressure cuff) is used to measure blood pressure.
 - i. Blood pressure is the pressure of circulating blood against the walls of the arteries.
- h. A blood pressure cuff contains the following components:
 - i. A wide outer cuff

- ii. An inflatable wide bladder sewn into a portion of the cuff
- iii. A ball-pump with a one-way valve
- iv. A pressure gauge calibrated in millimeters of mercury
- j. The palpation (feeling) method does not depend on your ability to hear sounds and should be used in certain cases to obtain a patient's blood pressure.
- k. Normal blood pressure
 - i. A patient has hypotension when the blood pressure is lower than the normal range and hypertension when the blood pressure is higher than the normal range.

F. Pupils (PEARRL)

Although we in Triage won't access the patient's pupils and their reaction, take note to see if the patient appears to be reacting appropriately to light and they track the activities going on. Be aware that the diameter and reactivity to light of the patient's pupils reflect the status of the brain's perfusion, oxygenation, and condition.

Pupil reactivity be indicate:

- a. Depressed brain function can be caused by the following situations:
 - i. Injury of the brain or brain stem
 - ii. Trauma or stroke
 - iii. Brain tumor
 - iv. Inadequate oxygenation or perfusion
 - v. Drugs or toxins (central nervous system depressants)
- b. Opiates, which are one category of central nervous system depressants, cause the pupils to constrict so significantly, regardless of light, that they become so small as to be described as pinpoint.
- e. PEARRL is a useful assessment guide:
 - i. Pupils
 - ii. Equal
 - iii. And
 - iv. Round
 - v. Regular in size
 - vi. React to Light

Initial Physical Exam

The physical examination may be a systematic assessment that focuses on a certain area or region of the body, often determined through the chief complaint. The purpose of the initial physical exam is strictly document the patients chief complaint and to determine if their condition warrants seeing the doctor, nurse, herbalist or mental health person. The exam is not meant to be detailed or requiring extensive physical contact with the patient. Male Triage persons should exercise caution when examining a child or women. It may be appropriate to ask another person to be present during the exam.

1. The assessment also includes collecting and documenting the patient's vital signs including, heart rate, blood pressure, respiratory rate and temperature.

- 2. Guidelines on how and what to assess during a physical examination:**
 - a. Inspection—Look at the patient for abnormalities; swelling, rashes, etc.**
 - b. Measurement- as part of taking vitals: pulse, blood pressure, temperature, etc.**
 - c. Glucose monitoring by trained personnel, noting skin color-temperature and moisture and well as level of consciousness may be documented as deemed appropriate.**

The mnemonic DCAP-BTLS reminds you what to look for:

- a. Deformities**
- b. Contusions**
- c. Abrasions**
- d. Punctures/penetrations**
- e. Burns**
- f. Tenderness**
- g. Lacerations**
- h. Swelling**

Compare findings on one side of the body with the other side when possible.

3. Neurologic system

- a. Are there obvious injuries, bruises, swelling to the head? Has the person experienced trauma or a fall?**
- b. A neurologic assessment should be performed any time you are confronted with a patient who has:**
 - i. Changes in mental status**
 - ii. A possible head injury**
 - iii. Stupor**
 - iv. Dizziness**
 - v. Drowsiness**
 - vi. Syncope**
- c. A neurologic assessment can be as simple as talking with the patient, asking questions, and receiving an appropriate reply from the patient.**
- d. Evaluate the LOC and orientation to determine the patient's ability to think clearly.**

4. Musculoskeletal system

- a. Assess for posture if standing, and look at joints, checking for range of motion.**
- b. Always compare the right side with the left side, looking for weakness or atrophy, and assess equality of grip strength.**

5. Extremities

- a. Inspect each extremity for symmetry, cuts, bruises, swelling, obvious injuries, bleeding rashes and sores.**
- b. Compare each extremity for deformities.**
- c. Check for pulses, motor function, and sensory function.**

6. Chest

- a. Are there obvious injuries, bruises or swelling? Has the person experienced trauma?**
- b. When assessing breathing, watch for both sides of the chest to rise and fall together with normal breathing.**

- c. Observe for abnormal breathing signs, including retractions or paradoxical motion.
- 7. Abdomen
 - a. Inquire about abdominal pain, tenderness, rigidity, is the patient guarding.
 - b. If a patient describes pain the abdomen, determine in what quadrant they are experiencing the pain. The abdomen is broken into four quadrants: left upper quadrant (LUQ), left lower quadrant (LLQ), right upper quadrant (RUQ), and right lower quadrant (RLQ).
 - c. Look for trauma to the abdomen and for distention.
 - d. Assess the patient's skin color and condition.
- 5. Determine whether your patient's condition is stable, stable but potentially unstable, or unstable.

Determine priority of patient; does this patient need to be seen immediately?

- 1. High-priority patients include those with any of the following conditions:
 - a. Difficulty breathing
 - b. Poor general impression
 - d. Severe chest pain
 - e. Pale skin or other signs of poor perfusion
 - h. Responsive but unable to follow commands
 - i. Severe pain in any area of the body

	BP Normal systolic	Pulse	Respiration
Adults	90-140mm hg	60-100 Beats	12-20 breathes/min
Adolescent 13-18 yrs	90-140 mm hg	60-100	12-20
School Age 6-12 yrs	80-110 mm hg	70-120	15-20
Pre-school 3-6 yrs	80-100 mm hg	80-140	20-25
Toddler 1-3 yr	80-100 mm hg	90-150	20-30
Infants to 1year	70-95 mm hg	100-160	25-50
New born to 1 month	50-70 mm hg	90-180	30-60

CHILD ABUSE

When you suspect there is a possibility of child abuse ask the following questions make sure to document any of your findings. We are mandatory reporters. If you suspect abuse, report your concerns to the doctor or to Sue.

- C** Are the child's injuries or symptoms inconsistent with child's age?
- H** Is the history you are getting inconsistent with the what you are observing?
- I** Is there inappropriate parental concern? A lack of concern for the extent of the injuries?
- L** Was / Is there a lack of supervision of the child?
- D** Was there a delay in seeking care? Was it reasonable?
- A** What is the affect of the caregiver?
- B** Are there bruises of varying ages?
- U** Are the bruises, burns or injuries that show an unusual injury pattern?
- S** Were there suspicious circumstances?
- E** Are the important environmental clues?

Guidelines for Glucose testing results

After determining how long it's been since the patient last ate, consider results as follows:

How long since eating	Blood sugar level	Next step
Currently measurement	<70	Give sugar or juice
1 hour after	<140	If greater than 140 see Dr
2 hours after	<120	If greater than 120 see Dr
12 hours after	<100	If greater than 100 see Dr