St. Joseph's Healthcare Hamilton

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:
   - ☐ Nutrition / weight loss
   - ☐ Incontinence
   - ☐ Failure to cope
   - ☐ Medication issues
   - ☐ Sensory deficits
   - ☐ Depression / low mood
   - ☐ 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.