OLIVE VIEW-UCLA MEDICAL CENTER
EVALUATION OF "CODE ASSIST "

Date: ________ **Location:** ________________ **Time Initiated:** ________ **Time Cleared:** ________
(Name & Room Number)

Patient Initials / MRN ________________________

Code Assist

Patient Assist Team Response:
Yes No Time: ________

Reason:
SZ
Fainting
Body Aches
Chest Pain
SOB
High BP
Other: ________________________________
____

Disposition: Patient Refused Care
Transferred to & time: ________

Mode of Transportation:
Ambulatory Stretcher
Wheel Chair

Comments: ____
____

Administrator : ____

Submit Evaluation Form to Urgent Care Supervisor

REVISED 09.13.12