**DATE:**

**ELEFANT NUMBER:**

**NAME:**

**Complains, symptoms**

**Abdominal pain**: yes / no

**if yes**: since when (hours):….………………………………………..

**type**: cramping / dull / sharp

**intensity (1-10**):……………………………………..

**location**: diffuse / localized

Please mark the location!

**radiation**:………………………………………………..

**Daily details and state**

**Blood pressure (Hgmm):**…………………… **Heart rate (/minute):**…………………………

**Body weight (kg):**……………………………… **Body height (cm):**…………………………………

**Respiratory rate (/minute):**………………. **Body temperature (°C):** ……………………..

axillary/rectal

**Oxygen saturation (%):** …………………… Previous O2 therapy: yes/no

**Abdominal tenderness :** yes / no **Abdominal guarding:** yes / no

**Jaundice**: yes / no

**Glasgow Coma Scale (GCS):**……………………………………….

Eye response:  
4 points: Spointsaneous eye opening  
3 points: Eye opening in response any speech  
2 points: Opening to response to pain  
1 points: No eye opening

Motor Response:  
6 points: Obeying command  
5 points: Localizing response to pain  
4 points: Withdraws to pain  
3 points: Decorticate posture  
2 points: Decerebrate posture  
1 points: No verbal response

Verbal Response:  
5 points: Oriented  
4 points: Confused conversation  
3 points: Inappropriate speech  
2 points: Incomprehensible speech  
1 points: No verbal response.