Safer Handoff

PATIENT HANDOFF CHECKLIST

INSERT INSTITUTION LOGO

All Items **must travel with patients** at all times to and/or from LTC facility/agency and emergency department.

- *Place a check mark beside each item as information is compiled and ready to be sent with the patient.*
- *Mark N/A if not applicable.*

	1. **Completed** copy of the *Patient Handoff Form.*
	2. Copy of medical records
	3. Copy of Face Sheet
	4. Copy of all treatments (Treatment Authorization Request (TAR))
	5. Copy of recent physician's orders (Personal Order Sets (POS) or Computerized physician order entry (CPOE))
	6. Copy of recent lab results
	7. Copy of EKG results
	8. Copy of X-ray, CT Scan, MRI results
	9. Copy of surgical reports
	10. Copy of Discharge Summary
	11. Medication Administration Record (MAR) — *Dosage, frequency, route, date started, usual administration times, date and time of last dose given*
	12. Advanced directives
	13. Code Status – *Copy of signed DNR*
	14. Copy of follow-up appointments/continued care recommendations
	15. Small assistive devices (hearing aides, eyeglasses, dentures, etc) in fanny pack or envelope
	16. Most recent rehab summary (e.g., weight-bearing status, assistive devices)
	17. Pacemaker information (model number, etc. needed for recalls)
	18. Information on special treatments (e.g., radiation, dialysis, total parenteral nutrition)
	19. Reason for original LTC facility admission: Long-term or rehabilitation
	20. Bedhold status

Safer Handoff

PATIENT HANDOFF/ TRANSFER FORM

INSERT INSTITUTION LOGO

DATE OF TRANSFER: _____/_____/_____

TIME OF TRANSFER: _____ : _____ **AM** **PM**

PATIENT INFORMATION

_____
Last Name *First Name* *MI*

_____
Street Address *City*

_____
State/Province *Zip/Postal Code*

_____/_____/_____
DOB

GENDER: M F

CONTACT PERSON/LEGAL GUARDIAN/DPOA

_____
Last Name *First Name*

( )
_____
Emergency Telephone

NOTIFIED *Yes* *No*

_____
Street, City, State/Province, Zip/Postal Code

_____
Relationship to Patient

NAME OF FACILITY TRANSFERRING FROM

_____
Facility Name *Address* *City* *State/Province* *Zip/Postal Code*

_____ ( )
_____
NAME OF RN/LPN/MD *in Charge of Patient at Time of Transfer* *Telephone*

REASON FOR TRANSFER

PRIMARY DIAGNOSIS

SECONDARY DIAGNOSIS

CODE STATUS

Copy of signed DNR Must Be Sent

DNR: ☐ Yes ☐ No **DNR Status**: ☐ CC ☐ CC Arrest **Full Code**: ☐ Yes ☐ No

ACUTE CHANGES FROM BASELINE ASSOCIATED WITH TRANSFER

VITAL SIGNS AT TRANSFER – TIME TAKEN: _____ : _____ AM PM

BP: /	TEMP:	PULSE:	RESP:	SaO_2: ☐ O_2 Therapy

IMMUNIZATION STATUS ☐ *Attached*

T.S.T. (PPD)	Date:	Results:	Hepatitis A:	Date:	☐ UNK
Influenza	Date:	☐ UNK	Hepatitis B:	Date:	☐ UNK
Pneumococcal	Date:	☐ UNK	Measles, Mumps, Rubella	Date:	☐ UNK
Meningococcal	Date:	☐ UNK	Varicella	Date:	☐ UNK
D.T.P.	Date:	☐ UNK	Inactivated Poliovirus	Date:	☐ UNK
Tetanus	Date:	☐ UNK			

TB Test	Date	Type	Result	***Biochem***	Date	Result	
Chest X-Ray	Date	Result		***Urinalysis***	Date	Result	
C.B.C.	Date	Result		***Fasting Glucose***	Date	Result	

ALLERGIES ☐ None ☐ UNK

Allergic To:	Reaction:	☐ UNK
Allergic To:	Reaction:	☐ UNK
Allergic To:	Reaction:	☐ UNK

ISOLATION/PRECAUTION

☐ None
☐ Contact
☐ Droplet
☐ Airborne

☐ MRSA	Date:	Site:	
☐ VRE	Date:	Site:	
☐ ESBL	Date:	Site:	
☐ Other	Date:		
☐ *C*-Diff.	Date:		

SKIN/ WOUND CARE ☐ Intact ☐ Not Intact

Describe Decubitus/ Wound (Size, Site, Drainage):

MENTAL/COGNITIVE STATUS

Recent Changes (within last 7 days): ☐ None ☐ Yes, *explain:*

☐ Alert ☐ Confused ☐ Dementia ☐ Delirium ☐ Depressed ☐ Comatose ☐ Agitated

Safer Handoff

PATIENT HANDOFF/ TRANSFER FORM

INSERT INSTITUTION LOGO

AT RISK ALERTS

- ☐ Fall
- ☐ Harm to Self
- ☐ Seizure
- ☐ Harm to Others (assaultive)
- ☐ Elopement
- ☐ Aspiration
- ☐ Impaired Safety Awareness
- ☐ Restraints
- ☐ Skin Failure (Breakdown) Braden Score:
- ☐ Other

TREATMENT RECEIVED WITHIN LAST 14 DAYS

- ☐ Chemotherapy
- ☐ Dialysis
- ☐ IV Medication
- ☐ Oxygen Therapy
- ☐ Transfusions
- ☐ Radiation Therapy
- ☐ Ventilator
- ☐ Tracheotomy Care
- ☐ Suctioning

IMPAIRMENT

- ☐ Mental
- ☐ Speech
- ☐ Hearing
- ☐ Vision
- ☐ Sensation

DISABILITIES

- ☐ Amputation
- ☐ Prosthesis
- ☐ Paralysis
- ☐ Paresis
- ☐ Contractures

SAFETY

- ☐ Restraints
- ☐ Sitter
- ☐ Wanders
- ☐ Siderails
- ☐ High Risk for Falls

INCONTINENCE

- ☐ Bladder
- ☐ Bowel
- ☐ Saliva

PATIENT USES

- ☐ Feeding Tube
- ☐ Foley Catheter
- ☐ Tracheotomy
- ☐ Central Line
- ☐ Ostomy
- ☐ Implant Defib
- ☐ Pacemaker

DECISION MAKING

- ☐ Independent
- ☐ Moderately Impaired
- ☐ Severely Impaired

ITEMS SENT WITH PATIENT *(Assistive Devices)*

- ☐ Glasses
- ☐ Hearing Aid
- ☐ Dentures
- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Prosthesis: Left Right
- ☐ Other:

DIET

Type of Diet:	☐ Regular	☐ Mechanical Soft	☐ Thickened Liquid	☐ Other:
Diet Restrictions:	☐ Cardiac	☐ Renal	☐ Diabetic	☐ Other:
Feeding Requirement:	☐ Independent	☐ Needs Assistance	☐ Dependent	☐ Tube Feed

SPECIAL CARE ORDERS

- ☐ Enemas PRN
- ☐ O_2 - - - - - - - - - - - - - - - - Liter Flow: _____
- ☐ IV Care/PICC - - - - - - - - Date: / / Length: _____ Site: _____ Verified by X-ray: ☐ Yes ☐ No
- ☐ Wound Care/ Dressing Changes:
- ☐ Suction
- ☐ Respiratory Care
- ☐ Ventilator/Settings TV: _____ PEEP: _____ PCO_2: _____ SAO_2: _____ SIMV: _____
- ☐ Additional Orders *(Includes tubes, Foleys, IVs)*:

LAB WORK

THERAPIES

- ☐ PT
- ☐ OT
- ☐ ST
- ☐ RT

ATTACHMENTS

- **MEDICAL RECORDS** ☐
- **FACE SHEET** ☐
- **TAR** *(TREATMENTS)* ☐
- **POS** *(PHYSICIAN'S ORDERS)* ☐
- **RECENT LABS** ☐
- **EKGS** ☐
- **XRAYS/CT SCANS/MRIS** ☐
- **SURGICAL REPORTS** ☐
- **DISCHARGE SUMMARY** ☐

MEDICATION ADMINISTRATION RECORD (MAR) ☐ Yes ☐ No *Attach current medication list*

FOLLOW-UP APPOINTMENTS/ CONTINUED CARE RECOMMENDATIONS

☐ Yes ☐ No *Attach*

ADVANCED DIRECTIVES *Copy Must Be Sent*

- ☐ Living Will
- ☐ DPOA for Healthcare
- ☐ No transfusions
- ☐ Other

FORM COMPLETED BY: Name:_____ Title: _____ Signature: _____

REPORT CALLED IN BY: Name:_____ Title: _____

REPORT CALLED TO: Name:_____ Title: _____