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

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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: _____