

Handover Communication Tool to Hospital

S	Date _____ Diagnosis _____ Attending Physician _____ Transfer Paperwork <input type="checkbox"/> Complete <input type="checkbox"/> Partially Complete <input type="checkbox"/> Not Done
B	Allergies _____ Code Status: DNR <input type="checkbox"/> Yes <input type="checkbox"/> No Include copy of POLST Most recent Ht: _____ Wt: _____ Infection: <input type="checkbox"/> MRSA <input type="checkbox"/> TB <input type="checkbox"/> C-diff <input type="checkbox"/> VRE <input type="checkbox"/> Other _____ History: <input type="checkbox"/> HTN <input type="checkbox"/> DM <input type="checkbox"/> CHF <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Seizures <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Bariatric <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> MI <input type="checkbox"/> CAPB Other _____
A	V/S: Time _____ B/P _____ Pulse _____ Temp _____ Resp _____ SpO2 _____ Recent Pain Score _____ Last Pain Med _____ Time _____ <input type="checkbox"/> Relieved <input type="checkbox"/> Decreased <input type="checkbox"/> No Change Neuro <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Non-responsive <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Combative <input type="checkbox"/> Sedated Other _____ Cardiac: Rhythm _____ Other _____ Respiratory: <input type="checkbox"/> O ₂ via _____ LPM _____ <input type="checkbox"/> Trach <input type="checkbox"/> Cough <input type="checkbox"/> Crackles <input type="checkbox"/> Wheezing <input type="checkbox"/> SOB Last Resp. Tx _____ Chest Tube/s: _____ Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Drainage _____ Other _____ GI: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting/Last Med _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gastric Tube <input type="checkbox"/> Ostomy Other _____ Last BM: _____ Changes in Bowel Function: _____ GU: <input type="checkbox"/> Voiding <input type="checkbox"/> Foley Other _____ Incontinence: _____ Skin Integrity (describe): _____ <input type="checkbox"/> Clean/Dry <input type="checkbox"/> Unable to address <input type="checkbox"/> Decubitus Location _____ <input type="checkbox"/> Not addressed Other _____ Ortho/Mobility <input type="checkbox"/> Bedrest HOB: <input type="checkbox"/> Up <input type="checkbox"/> Down <input type="checkbox"/> Amb w/Assistance <input type="checkbox"/> Splint Other _____ Fall Risk: _____ Psych/Social On Admission: <input type="checkbox"/> Accompanied <input type="checkbox"/> Alone <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Non-English Speaking <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Psychiatric Diagnosis Other _____
R	Pertinent lab tests <u>In Progress</u> _____ Family notified of admission: <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ Nurse (Please Print) _____ Person Notified of pending Patient Arrival _____ Time _____
Situation	
Background	
Assessment	
Recommendation	