## Communication Hand-Off Progress Note

**Complete entire form for patients being admitted, transferred to another unit/facility, or going to a procedural area.**

**Complete gray highlighted areas only for patients going to diagnostic testing sites (radiology, CT scan, MRI, etc.)**

<table>
<thead>
<tr>
<th>TRANSFER FROM:</th>
<th>TRANSFER TO:</th>
<th>SERVICE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Verbal Report Checklist**

- **Brief History** (Including reason for admission)
  - Admission
  - Change in status
  - Change in service
  - Other

- **Reason for Transfer**
  - Patient condition: Improving
  - No change
  - Worsening

- **Assessment of Patient Condition**
  - Allergies: None known
  - Meds:
  - Food:
  - Latex

- **Safety Precautions**
  - Isolation: Contact:
  - MRSA
  - VRE
  - Gram negative
  - Airborne
  - Droplet
  - High risk fall precautions
  - Fall this admission (date):
  - DVT risk
  - Sitter with patient:
  - Yes
  - No
  - Restraints this admission:
  - Yes
  - No
  - Type:

- **Code Status**
  - Full/unlimited resuscitation:
  - Do not resuscitate
  - Do not initiate

- **Assessment**
  - Nursing assessment complete:
  - Yes
  - No
  - Comments:

- **Vital Signs**
  - Most recent VS: BP
  - Pulse:
  - Resp rate:
  - Temp:
  - O2 sat:

- **Pain**
  - Present
  - Not present
  - Pain score
  - Location/description
  - Last analgesic administered:
  - Dose:
  - Route:
  -Time:
  - Effective:
  - Y
  - N

**Pertinent Review of Systems**

- **Neurological**
  - Neurological status (check all that apply):
  - Awake
  - Drowsy
  - Unresponsive
  - Confused
  - Other
  - GCS:
  - Orientation:
  - Person
  - Place
  - Time
  - Situation
  - Comment:
  - Sensory deficits:
  - Hearing
  - Vision
  - Speech
  - Other:

- **Activity Level**
  - Independent with ADLs:
  - Yes
  - No
  - Up ad lib
  - Up with assist
  - Bed rest

- **Cardiovascular**
  - Cardiac monitoring:
  - Yes
  - No
  - Heart rhythm (where applicable):
  - Arrhythmias (specify):
  - Invasive monitoring (specify type and parameters):
  - Peripheral pulses:
  - Present
  - Absent
  - Comments:

- **Respiratory**
  - Breathing sounds:
  - Oxygen:
  - Artificial airway:
  - Tracheotomy (size and type):
  - ETT (size):
  - Respiratory treatments (type/frequency):
  - Chest tube:
  - Mechanical Ventilation:
  - Yes
  - No
  - Vent Settings:
  - Last ABG (specify abnormalities):
  - Time:

- **Nutrition**
  - Type of diet:
  - NPO
  - Assist with feeding
  - Total feeding
  - Tube feeding (specify):
  - Parenteral nutrition (type/rate):
  - Fluid restriction/Amount:

- **Skin**
  - Intact
  - Most recent Braden score:
  - Wound Location:
  - Description:
  - Wound care (type/frequency):
  - Last dressing change (time):

- **Elimination**
  - Urine
  - Incontinent
  - Foley size/date of insertion
  - Hemodialysis
  - Bowel sounds:
  - Present
  - Absent
  - Comments:
  - Tubes/drains (specify):

*See Back for Additional Information*
<table>
<thead>
<tr>
<th><strong>Patient Name:</strong></th>
<th><strong>MR #:</strong></th>
</tr>
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</table>

| **PSYCHOSOCIAL** | Significant history: |

| **DISCHARGE PLAN/PATIENT EDUCATION/PLAN OF CARE** | Services involved: PT  OT Social Work Nutrition Case Mgt Other Patient education up to date: Yes No Plan of Care up to date: Yes No Core measures (specify): Pneumonia/Flu vaccine needed: Yes No |

| **MEDICATIONS** | Diabetic: Yes Insulin: ----------------------------------- Last blood glucose: ----------------------------------- See MAR New antibiotic started (drug/dose/time): ----------------------------------- Drug levels needed (type and time): ----------------------------------- Recent sedation (drug and time): RASS |

<table>
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<tr>
<th><strong>IV FLUIDS/LINES</strong></th>
<th>Type/location</th>
<th>Fluid</th>
<th>Rate</th>
<th>Amount in bag</th>
</tr>
</thead>
</table>

| **TRANSFUSION** | Type and cross specimen sent (date/time): ----------------------------------- NA Blood product transfusions within last 24 hours: Yes No Date/time: History of Blood product reaction: Yes No Details (specify): |

| **LAB RESULTS** | Abnormal results (specify): |

<table>
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<tr>
<th><strong>EQUIPMENT</strong></th>
<th>Special equipment sent with patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment needed for patient upon arrival to unit:</td>
<td></td>
</tr>
</tbody>
</table>

| **TRANSFER TASKS** | Medications: Sent with patient Sent to pharmacy Other: Belongings: Sent with patient With Family Security Other: Old records: Sent with patient Medical Records |

| **OTHER PERTINENT INFORMATION** | Additional Comments: |

| **SIGN OFF** | Transferring RN/MD Printed Name Signature Accepting RN/MD Printed Name Unit Name Time of Actual Transfer |

Use the space below to communicate changes from the above documentation (for instance, if there are changes since taking over care of the patient and prior to sending to another area).

Additional Hand-off:

Signature: __________________________ Date/time: __________________________ Unit: __________________________

Additional Hand-off:

Signature: __________________________ Date/time: __________________________ Unit: __________________________

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