# TRANSFER PATIENT ASSESSMENT

## Transferring Unit Patient Assessment

<table>
<thead>
<tr>
<th>Transferring Unit:</th>
<th>Date:</th>
</tr>
</thead>
</table>

## Brief Review of Hospital Course:

- [ ] None
- [ ] Upper Dentures
- [ ] Lower Dentures
- [ ] Eyeglasses
- [ ] Contact Lenses

### Assisive Devices:

- [ ] Hearing Aid
- [ ] Cane
- [ ] Crutches
- [ ] Walker
- [ ] Prosthetic Device
- [ ] Other (Specify):

### Sensory Deficits:

- [ ] None
- [ ] Visually Impaired
- [ ] Blind
- [ ] Hearing impaired
- [ ] Deaf
- [ ] Other

### Indwelling Treatment Devices:

- [ ] None
- [ ] Implanted Vascular Access Device
- [ ] Peripherally Inserted Central Catheter (PICC)
- [ ] Peripheral IV (site)

### Falls Risk Protocol Implemented:

- [ ] Yes
- [ ] No

### Medications Sent with patient:

- [ ] Yes
- [ ] No

**Last dose of prn medication:**

- [ ] None within the past 24 hours

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

### Personal Belongings with patient:

- [ ] Yes
- [ ] No

**If no, explain:**

### ID Band present and correct:

- [ ] Yes

**Allergy ID Band present, if needed:**

- [ ] Yes
- [ ] Not needed

### Vital Signs on Transfer:

- [ ] T:
- [ ] P:
- [ ] R:
- [ ] BP:

### Verbal Report given by:

- [ ] to

### Signature:

**Time Transferred:**