

## Hand Off Communication Worksheet

Patient Name: \_\_\_\_\_ M.D. \_\_\_\_\_

Admitting M.D.: \_\_\_\_\_ Patient Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Code Status: \_\_\_\_ DNR \_\_\_\_ DNI \_\_\_\_ Not addressed

Family/Significant Other Location: \_\_\_\_\_

Pertinent History: \_\_\_\_\_  Not AddressedPatient responsible for own consent:  Yes  No

If No, legal guardian or POA: \_\_\_\_\_

**Treatments/Assessment:**

Mentation: Alert \_\_\_\_ Oriented \_\_\_\_ Confused \_\_\_\_ Obtunded \_\_\_\_

Other: \_\_\_\_\_

Vital Signs: T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ B/P \_\_\_\_\_ SaO2 \_\_\_\_\_

Oxygen: \_\_\_\_ No \_\_\_\_ Yes

Critical Labs: \_\_\_\_\_

Pain Score: \_\_\_\_\_

Meds Given: \_\_\_\_\_

Meds Reconciliation done? \_\_\_\_ Yes \_\_\_\_ No

**Tubing/Line Reconciliation**

SL \_\_\_\_\_ Fluid Rate \_\_\_\_\_ Med Running \_\_\_\_\_

Foley \_\_\_\_ NG \_\_\_\_ Other \_\_\_\_\_

**Special Concerns:**

None \_\_\_\_

NPO \_\_\_\_

Impairments: Hearing \_\_\_\_ Visual \_\_\_\_ Cognitive \_\_\_\_ Mobility \_\_\_\_ Other \_\_\_\_\_

Fall Risk \_\_\_\_

Infectious Disease precautions level \_\_\_\_

Run Risk \_\_\_\_

Suicide Precautions \_\_\_\_

Other: \_\_\_\_\_