Inter-departmental Communication form

Name: _____ **Room:** _____ **Doctor:** _____

Allergies: _____

Code Status: ☐ Full Code ☐ DNR ☐ Limited Resuscitation

Fall Risk: ☐ Up per Self ☐ Up with 1 2 3 (circle) ☐ Unable to stand

Mental Status: ☐ Alert & Oriented ☐ Forgetful ☐ Confused / Dementia

Barriers: ☐ HOH ☐ Deaf ☐ Poor vision ☐ Blind ☐ Language Barrier

Infection Risk: ☐ MRSA ☐ VRE

Date	Department	Time Out (name)	Time Back (Name)	Mode of Transportation	Test Complete and Report Given

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