PATIENT TRANSFER SUMMARY

Transfer From:_____________________________ To: ______________________________ Date:_______________

SITUATION: **DNR: ❑No ❑ Yes**

Diagnosis/hx present illness:______________ ____ ____	PRECAUTIONS: Falls Risk: ❑ No ❑ Yes Interventions: ❑ Sitter ❑ Bed Alarm Isolation: ❑ No ❑ Yes Type:_____________ Restraints: ❑ No ❑ Yes

VS: T_________ P ___________R________ BP____________ SPO_2__________

Surgical Procedure: ____

Anesthesia: ❑ General ❑ Spinal ❑ Block ❑ Local ❑ Other ____________ EBL_________________

VENT SETTINGS: FIO_2____ vT ____ PEEP_____ Last ABG: pH____ PCO_2_____ PO_2____ Other____________

Allergies:❑ No ❑ Yes ____

Pertinent History/Abnormal Findings: ____

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Family Notified: ❑ No ❑ Yes Comments:____

CURRENT STATUS:

NEURO: ❑ A&O ❑ Confused ❑ Agitated ❑ Combative ❑ Lethargic ❑Unresponsive

PULM: ❑ NA ❑Clear ❑ Labored ❑ Non-Labored	❑ Rhonchi/Rales ❑R ❑ L ❑ Bil	❑ Wheezing ❑ R ❑ L ❑ Bil	❑ Diminished ❑ R ❑ L ❑ Bil	O_2 _______l/m via _______

CV: ❑ NA ❑ Pulses Palpable ❑ Peripheral Edema ❑ Cyanosis ❑ Telemetry: ❑ No ❑ Yes Rhythm_________

GI/ABD: ❑ NA ❑ Soft ❑ Bowel Sounds: ❑ Present ❑ Absent ❑ Hypo ❑ Hyper ❑ Last BM__________
❑ Distended ❑ Obese ❑ Tender ❑ Non-tender ❑ Nausea ❑ Vomiting ❑ Diarrhea ❑ Constipation
❑ NPO

GU: ❑ NA ❑ Voiding Foley/Size _____________ Output ______________ Color _____________

SKIN: ❑NA Dressings:______________________ Surgical/Wound Site:____________________________
Drains/Tubes:____________________ Chest tube: _________________Splints: ____________________
Other:____ ❑ Wound Assessment Form Initiated

MEDICATIONS: ❑ None ❑ Meds Given:________________________________ Last Abx/Time:______________
IV Site: Peripheral___________________________Central Line:__________ PICC: ___________________________
IV Solution___________ml/hr Blood ________________ml/hr Amount Infused _______________________
❑ PCA Medication ____ rate _______________

PAIN SCALE @ this time: _______ Location: ______________ Last sedative/narcotic given: ________________

VALUABLES/BELONGINGS: ❑ With Pt ❑ With Family ❑ Brought to Room #:_________
Other____

Review Pending Orders, Results, Interventions:

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Signature of Sending Nurse	*Time*	*Ext.*	*Signature of Nurse Receiving Report*	*Time*

Patient Label