All Items **must travel with patients** at all times to and/or from LTC facility/agency and emergency department.

- Place a check mark beside each item as information is compiled and ready to be sent with the patient.
- Mark N/A if not applicable.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Completed</strong> copy of the Patient Handoff Form.</td>
</tr>
<tr>
<td>2.</td>
<td>Copy of medical records</td>
</tr>
<tr>
<td>3.</td>
<td>Copy of Face Sheet</td>
</tr>
<tr>
<td>4.</td>
<td>Copy of all treatments (Treatment Authorization Request (TAR))</td>
</tr>
<tr>
<td>5.</td>
<td>Copy of recent physician’s orders (Personal Order Sets (POS) or Computerized physician order entry (CPOE))</td>
</tr>
<tr>
<td>6.</td>
<td>Copy of recent lab results</td>
</tr>
<tr>
<td>7.</td>
<td>Copy of EKG results</td>
</tr>
<tr>
<td>8.</td>
<td>Copy of X-ray, CT Scan, MRI results</td>
</tr>
<tr>
<td>9.</td>
<td>Copy of surgical reports</td>
</tr>
<tr>
<td>10.</td>
<td>Copy of Discharge Summary</td>
</tr>
<tr>
<td>11.</td>
<td>Medication Administration Record (MAR) — Dosage, frequency, route, date started, usual administration times, date and time of last dose given</td>
</tr>
<tr>
<td>12.</td>
<td>Advanced directives</td>
</tr>
<tr>
<td>13.</td>
<td>Code Status — Copy of signed DNR</td>
</tr>
<tr>
<td>14.</td>
<td>Copy of follow-up appointments/continued care recommendations</td>
</tr>
<tr>
<td>15.</td>
<td>Small assistive devices (hearing aides, eyeglasses, dentures, etc) in fanny pack or envelope</td>
</tr>
<tr>
<td>16.</td>
<td>Most recent rehab summary (e.g., weight-bearing status, assistive devices)</td>
</tr>
<tr>
<td>17.</td>
<td>Pacemaker information (model number, etc. needed for recalls)</td>
</tr>
<tr>
<td>18.</td>
<td>Information on special treatments (e.g., radiation, dialysis, total parenteral nutrition)</td>
</tr>
<tr>
<td>19.</td>
<td>Reason for original LTC facility admission: Long-term or rehabilitation</td>
</tr>
<tr>
<td>20.</td>
<td>Bedhold status</td>
</tr>
</tbody>
</table>
**Date of Transfer:** / /  
**Time of Transfer:** : AM PM

**Patient Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>State/Province</th>
<th>Zip/Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB</th>
<th>Gender:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

**Contact Person/Legal Guardian/DPOA**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Telephone</th>
<th>NOTIFIED: Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Street, City, State/Province, Zip/Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Relationship to Patient**

**Name of Facility Transferring From**

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Zip/Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Reason for Transfer**

**Secondary Diagnosis**

**Primary Diagnosis**

**Code Status**

- DNR: [ ] Yes [ ] No
- DNR Status: [ ] CC [ ] CC Arrest Full Code: [ ] Yes [ ] No
- DNR Must Be Sent
- Copy of signed DNR

**Vital Signs at Transfer**

- Time Taken: : AM PM
- BP: /  
- TEMP:  
- PULSE:  
- RESP:  
- SaO₂:  
- O₂ Therapy

**Immunization Status**

- Attached

<table>
<thead>
<tr>
<th>T.S.T. (PPD)</th>
<th>Date:</th>
<th>Results:</th>
<th>Hepatitis A:</th>
<th>Date:</th>
<th>Results:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.T.P.</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td>Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Date: UNK

<table>
<thead>
<tr>
<th>TB Test</th>
<th>Date</th>
<th>Type</th>
<th>Result</th>
<th>Biochem</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-Ray</td>
<td>Date</td>
<td>Result</td>
<td></td>
<td>Urinalysis</td>
<td>Date</td>
<td>Result</td>
</tr>
<tr>
<td>C.B.C.</td>
<td>Date</td>
<td>Result</td>
<td></td>
<td>Fasting Glucose</td>
<td>Date</td>
<td>Result</td>
</tr>
</tbody>
</table>

**Allergies**

- None [ ] UNK [ ]
- Allergic To: [ ] Reaction:

<table>
<thead>
<tr>
<th>Isolation/Precaution</th>
<th>Date</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>VRE</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

**Skin/Wound Care**

- Intact [ ] Not Intact [ ]

**Isolation/Precaution**

- MRSA Date Site
- VRE Date Site
- Other Date

**Mental/Cognitive Status**

- Recent Changes (within last 7 days): None [ ] Yes, explain:

<table>
<thead>
<tr>
<th>Alert</th>
<th>Confused</th>
<th>Dementia</th>
<th>Delirium</th>
<th>Depressed</th>
<th>Comatose</th>
<th>Agitated</th>
</tr>
</thead>
</table>

Safer Handoff of Older Adult Patients

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**PATIENT HANDOFF/TRANSFER FORM**

**AT RISK ALERTS**
- Fall
- Harm to Self
- Seizure
- Restraints
- Harm to Others (assaultive)
- Elopement
- Aspiration
- Impaired Safety Awareness
- Skin Failure (Breakdown)
- Other

**TREATMENT RECEIVED WITHIN LAST 14 DAYS**
- Chemotherapy
- Dialysis
- IV Medication
- Oxygen Therapy
- Transfusions
- Radiation Therapy
- Ventilator
- Tracheotomy Care
- Suctioning

**IMPAIRMENT**
- Mental
- Speech
- Hearing
- Vision
- Sensation

**DISABILITIES**
- Amputation
- Prosthesis
- Paralysis
- Sclerales
- Contractures

**SAFETY**
- Restraints
- Sitter
- Wanders
- Siderails
- High Risk for Falls

**INCONTINENCE**
- Bladder
- Bowel
- Saliva

**PATIENT USES**
- Feeding Tube
- Foley Catheter
- Tracheotomy
- Central Line
- Ostomy
- Implant Defib
- Pacemaker

**DECISION MAKING**
- Independent
- Moderately Impaired
- Severely Impaired

**ITEMS SENT WITH PATIENT**
- (Assistive Devices)
  - Glasses
  - Hearing Aid
  - Crutches
  - Walker
  - Prosthesis: Left
  - Right

**DIET**
- Type of Diet: Regular
- Mechanical Soft
- Thickenened Liquid
- Other:
- Diet Restrictions: Cardiac
- Renal
- Diabetic
- Other:
- Feeding Requirement: Independent
- Needs Assistance
- Dependent
- Tube Feed

**SPECIAL CARE ORDERS**
- Enemas PRN
- O2 ____________ Liter Flow: ____________
- IV Care/PC/ICC Date: / / Length: ______ Site: ______ Verified by X-ray: Yes No
- Wound Care/ Dressing Changes: ____________
- Suction
- Respiratory Care
- Ventilator/Settings
- TV: ________ PEEP: ________ PCO2: ________ SAO2: ________ SIMV: ________

**LAB WORK**

**THERAPIES**
- PT
- OT
- ST
- RT

**ATTACHMENTS**

**MEDICAL RECORDS**
- Face Sheet
- TAR (TREATMENTS)
- POS (PHYSICIAN’S ORDERS)
- Recent Labs
- EKGs
- Xrays/CT Scans/MRIs

**MEDICATION ADMINISTRATION RECORD (MAR)**
- Yes
- No
- Attach current medication list

**FOLLOW-UP APPOINTMENTS/CONTINUED CARE RECOMMENDATIONS**
- Yes
- No
- Attach

**ADVANCED DIRECTIVES**
- Living Will
- DPOA for Healthcare
- No transfusions
- Other

**FORM COMPLETED BY:**
- Name: ___________________________
- Title: ___________________________
- Signature: ______________________

**REPORT CALLED IN BY:**
- Name: ___________________________
- Title: ___________________________

**REPORT CALLED TO:**
- Name: ___________________________
- Title: ___________________________