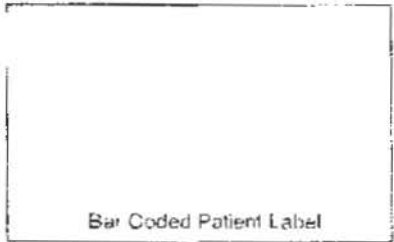


CU/CCU NURSING TRANSFER SUMMARY



Smoker within the past year: YES NO

Cardiovascular:

Gastrointestinal:

LBM:

Genitourinary:

Skin:

IV Lines/Drains (locations and insertion dates)

Is patient assessed as a Fall Risk: NO YES (ensure protocol in place on transfer)

Transfer summary written by: _____ Date: _____

Transfer summary updated by: _____ Date: _____

Report called to: _____ Unit: _____ Time: _____

Patient transfer time: _____ Via: _____

Patient transferred by: _____ Via: _____ Monitored: YES NO