University of Medical Center

Communication Hand-Off Progress Note

Complete entire form for patients being admitted, transferred to another unit/facility, or going to a procedural area.

Complete grey highlighted areas only for patients going to diagnostic testing sites (radiology, CT scan, MRI, etc.)

TRANSFER FROM:	TRANSFER TO:	SERVICE:
DATE/TIME OF TRANSFER:		

Verbal Report Checklist	Written Summary Section
☐ **BRIEF HISTORY** (Including reason for admission)	
☐ **REASON FOR TRANSFER**	☐ Admission ☐ Change in status ☐ Change in service ☐ Other
☐ **ASSESSMENT OF PATIENT CONDITION**	Patient condition: ☐ Improving ☐ No change ☐ Worsening
☐ **ALLERGIES**	☐ None known ☐ Meds: ☐ Food: ☐ Latex
☐ **SAFETY PRECAUTIONS**	Isolation: Contact: ☐ MRSA ☐ VRE ☐ Gram negative ☐ Airborne ☐ Droplet ☐ High risk fall precautions ☐ Fall this admission (date): _____ ☐ DVT risk Sitter with patient: ☐ Yes ☐ No Restraints this admission: ☐ Yes ☐ No Type: _____
☐ **CODE STATUS**	☐ Full/unlimited resuscitation ☐ Do not resuscitate ☐ Do not initiate _____
☐ **ASSESSMENT**	Nursing assessment complete: ☐ Yes ☐ No Comments:
☐ **VITAL SIGNS**	Most recent VS: BP _____ Pulse: _____ Resp rate: _____ Temp: _____ O2 sat _____
☐ **PAIN**	☐ Present ☐ Not present Pain score _____ Location/description _____ Last analgesic administered: _____ Dose: _____ Route _____ Time _____ Effective ☐ Y ☐ N
	PERTINENT REVIEW OF SYSTEMS
☐ **NEUROLOGICAL**	Neurological status (check all that apply) ☐ Awake ☐ Drowsy ☐ Unresponsive ☐ Confused ☐ Other _____ GCS: _____ Orientation to: ☐ Person ☐ Place ☐ Time ☐ Situation Comment: _____ Sensory deficits: ☐ Hearing ☐ Vision ☐ Speech ☐ Other: _____
☐ **ACTIVITY LEVEL**	Independent with ADLs: ☐ Yes ☐ No ☐ Up ad lib ☐ Up with assist ☐ Bed rest
☐ **CARDIOVASCULAR**	Cardiac monitoring: ☐ Yes ☐ No Heart rhythm (where applicable): _____ Arrhythmias (specify): _____ Invasive monitoring (specify type and parameters): _____ Peripheral pulses: ☐ Present ☐ Absent Comments: _____
☐ **RESPIRATORY**	Breath sounds: _____ Oxygen: _____ Artificial airway: ☐ Tracheostomy (size and type): _____ ☐ ETT (size): _____ Respiratory treatments (type/frequency): _____ ☐ Chest tube _____ Mechanical Ventilation: ☐ Yes ☐ No Vent Settings: _____ Last ABG (specify abnormalities): _____ Time: _____
☐ **NUTRITION**	Type of diet: _____ ☐ NPO ☐ Assist with feeding ☐ Total feeding ☐ Tube feeding (specify) _____ ☐ Parenteral nutrition (type/rate) _____ ☐ Fluid restriction/Amt _____
☐ **SKIN**	☐ Intact Most recent Braden score: _____ ☐ Wound Location: _____ Description: _____ ☐ Wound care (type/frequency): _____ Last dressing change (time): _____
☐ **ELIMINATION**	☐ Voids ☐ Incontinent ☐ Foley size/date of insertion _____ ☐ Hemodialysis Bowel sounds: ☐ Present ☐ Absent Comments: _____ Tubes/drains (specify): _____

See Back for Additional Information*

Patient Name: _____ **MR #:** _____

☐ **PSYCHOSOCIAL**	Significant history:
☐ **DISCHARGE PLAN/ PATIENT EDUCATION/ PLAN OF CARE**	Services involved: ☐ PT ☐ OT ☐ Social Work ☐ Nutrition ☐ Case Mgt ☐ Other _____ Patient education up to date: ☐ Yes ☐ No Plan of Care up to date: ☐ Yes ☐ No Core measures (specify): _____ Pneumonia/flu vaccine needed: ☐ Yes ☐ No
☐ **MEDICATIONS**	Diabetic: ☐ Yes ☐ Insulin: _____ ☐ Last blood glucose: _____ ☐ See MAR ☐ New antibiotic started (drug/dose/time): _____ ☐ Drug levels needed (type and time): _____ ☐ Recent sedation (drug and time): _____ RASS _____

☐ **IV FLUIDS/LINES**	Type/location	Fluid	Rate	Amount in bag

☐ **TRANSFUSION**	Type and cross specimen sent (date/time) _____ ☐ NA Blood product transfusions within last 24 hours: ☐ Yes ☐ No Date/time: _____ History of Blood product reaction: ☐ Yes ☐ No Details (specify) _____
☐ **LAB RESULTS**	Abnormal results (specify): _____ Interventions (if applicable): _____
☐ **EQUIPMENT**	Special equipment sent with patient: _____ Equipment needed for patient upon arrival to unit: _____
☐ **TRANSFER TASKS**	Medications: ☐ Sent with patient ☐ Sent to pharmacy ☐ Other: _____ Belongings: ☐ Sent with patient ☐ With Family ☐ Security ☐ Other: _____ Old records: ☐ Sent with patient ☐ Medical Records
OTHER PERTINENT INFORMATION	Additional Comments: ☐ See progress note/flowsheet for further information.
SIGN OFF	Transferring RN/MD _____ (Printed Name) _____ (Signature) Accepting RN/MD _____ (Printed Name) _____ (Unit Name) Time of Actual Transfer _____

Use the space below to communicate changes from the above documentation (for instance, if there are changes since taking over care of the patient and prior to sending to another area).

Additional Hand-off:

Signature: _____ Date/time: _____ Unit: _____

Additional Hand-off:

Signature: _____ Date/time: _____ Unit: _____