Hospital Center

NURSING DEPARTMENT

TRANSFER PATIENT ASSESSMENT

Transferring Unit Patient Assessment

Transferring Unit: **Date:**

Brief Review of Hospital Course:

Assistive Devices:

☐ None		☐ Hearing Aid	☐ with pt	☐ Prosthetic Device	☐ with pt
☐ Upper Dentures	☐ with pt	☐ Cane	☐ with pt	Specify: _____	
☐ Lower Dentures	☐ with pt	☐ Crutches	☐ with pt	☐ Other (Specify):	☐ with pt
☐ Eyeglasses	☐ with pt	☐ Walker	☐ with pt	_____	
☐ Contact Lenses	☐ with pt				

Sensory Deficits: ☐ None ☐ Visually Impaired ☐ Blind ☐ Hearing Impaired ☐ Deaf ☐ Other

Indwelling Treatment Devices:

☐ None	☐ Shunts	☐ Chest Tube
☐ Implanted Vascular Access Device	☐ Indwelling Catheter	☐ N/G Tube
☐ Peripherally Inserted Central Catheter (PICC)	☐ Drains _____	☐ Feeding Tube
☐ Peripheral IV (site) _____	☐ Other _____	

Falls Risk Protocol Implemented ☐ Yes ☐ No

Medications Sent with patient ☐ Yes ☐ No

Last dose of prn medication: ☐ None within the past 24 hours

Drug	Dose	Date/Time

Personal Belongings with patient: ☐ Yes ☐ No If no, explain:

ID Band present and correct: ☐ Yes

Allergy ID Band present, if needed: ☐ Yes ☐ Not needed

Vital Signs on Transfer: T: P: R: BP:

Verbal Report given by: to

Signature: **Time Transferred:**

(05/02)