McLaren

THUMB REGION

HAND-OFF REPORT

Situation

Patient moving from:_____ to:_____ Stable Improving Deteriorating

Primary Diagnosis:_____

Admitting Physician:_____

Code Status: Full Code No Intubation DNR Comfort Care

Allergies_____

Recent Vital Signs: T:_____ B/P:_____ P:_____ RR:_____ Sat:_____% on _____ 02

High Risk for Falls: Yes No If yes, initiate fall risk protocol

Core Measures Diagnosis: CHF CAP AMI SCIP None

Medication Reconciliation Form Completed: Yes No

If CAP pt: Blood Cultures Done? Yes No Time Abx Started:_____

Summary of Current Physical Condition:

_____

_____

Background

Pertinent Past Medical History:

_____

_____

Isolation: None Contact Contact Enhanced Droplet Airborne

Restraints: Type:_____ None

Abnormal diagnostics/critical values:

_____

_____

Special Circumstances/Medications given and time:

_____

_____

Assessment

ASSESSMENT:

Respiratory:_____

Cardiovascular:_____

IV Fluids/Additives/Rate:_____

I&O:_____

Skin Integrity:_____

LOC: Oriented Disoriented Confused Unresponsive Recent Change

Neuro:_____

Visual or Hearing Impairment: No Yes:_____

Musculoskeletal:_____

GI:_____ GU:_____

Pain Level (1-10):_____ Last Medicated:_____

Recom.

RECOMMENDATIONS:

Treatment/Care/Service that needs to be completed:_____

Special Needs of Patient/Family:_____

If going for procedure, consent signed? Yes No

This is for reporting purposes only. This is not part of the permanent medical record