Patient Name:	Sending RN:
Date and Time:	Receiving RN:
Primary diagnosis and any complications during hospital stay	

SAFETY/Basic Info

Precautions (if other than standard)

Do we have a copy of the Health Care Proxy? Yes ☐ No ☐

Have they been on any 1:1 or restraints? Yes ☐ No ☐

Code status Full ☐ DNR ☐

Functional status: assistance needs	Use of any devices: walker ☐ hoyer ☐ bariatric equipment ☐ hearing aid ☐ glasses ☐ dentures ☐

CLINICAL INFO

Most recent vital signs

Are they on O2? Yes ☐ No ☐	Flow rate and type
Have they been on an IV? Yes ☐ No ☐	Last pain med/time?

Diet – Restrictions? Allergies? Tube feedings?

Last BM (see below)	List other meds of concern? Insulin? Flu? Pneumovax?

If no BM during hospital stay requires verbal communication with receiving facility

Special needs? Yes ☐ No ☐ Ostomy, wound or other supplies Yes ☐ No ☐ What size?	Do we have any scripts necessary to send with the patient to allow meds to get filled – narcotics or IVs, antibiotics, respiratory meds? Yes ☐ No☐ **IF NO, WHAT IS THE PLAN? Requires verbal communication with receiving facility.**

Continent of Stool Yes ☐ Incontinent Yes ☐	Last PT/INR and what was last dose of Coumadin
Continent of Urine Yes ☐ Incontinent Yes ☐	
If foley recently removed within past 24 hours, date/time?	Any test results pending / Any test results to be scheduled
Skin issues	Labs of concern or pending?

Other tests and important follow-ups needed in plan of care (family issues, conflicts, patient preferences)?
Interpreter needs? Yes ☐ No ☐
THIS REQUIRES VERBAL COMMUNICATION WITH RECEIVING FACILITY.