KC4TP WARM HANDOVER GUIDE

NAME: ______________________________________

Report is being given by: (LN) @ (facility) to (LN) @ (facility)

CALL BACK NUMBER for additional questions:

Current Ht & Wt	HT: WT:	1:1 STATUS: N/A Date and time off 1:1
Pts Chief Complaint		
Primary Diagnosis		
Additional Diagnosis		
Recent Vital Signs Oxygen Needs	BP: T: P: R: O2 sat: on Room Air or: L/minutes Mask Cannula Nebulizer BiPap Current Liter flow: 1 2 3 4 5 or: ______Liters	
Surgery Date ____________	Surgeon: Surgical Procedure: Incisions is Closed Open Location: Cast: No Yes Location:	
Orientation	Alert and Oriented to: Self Time Location x3 Circumstances x4	
Competence	Sign documents for self? No Yes If no who is responsible? Contact # Able to verbalize understanding of diagnosis and treatment: No Yes	
Diabetes Diagnosis	N/A Yes If yes, is BG stable? No Yes Last BG @: results:	
Anticoagulation	Is resident on an anticoagulant? No Yes: Heparin Lovenox Fragmin Coumadin Plavix ASA Date of last PT/INR: Results: Next draw due @:	
Pain Issues	No Yes Last medicated @ with (medication)	
Wound Issues Dressing Changes	N/A Yes Location: Wound Vac N/A Yes Dressing orders: No Yes: Dressing last changed on (date) @ (time)	
Bowel Issues	Continent: No Yes Last date BM recorded:	
Bladder issues	Continent: No Yes Catheter: No Yes Last changed or removed on (date) @ (time)	
Swallowing Issues	No Yes Texture of current diet Liquid Consistency: Thin Nectar Honey Spoon	
Enteral Feeding	No Yes: Type: Volume: Frequency/Rate	
Ambulation/Transfer	Ambulatory: No Yes Wt bearing: No Partial Full Transfer requires: 1 or 2 person lift	
Assistive Devices	No Yes: FWW 4WW Cane WC Oversized WC	
Special Equipment	No Yes	
Intravenous Lines	Type: Location: Date IV inserted or last changed:	
Medications	Time last meds passed: On IV medication: No Yes Next IV med due at:	
Personal Preferences		
Palliative Care	Did the patient receive a Palliative Care consult while in the hospital? NO YES	

7/16/13