**THE UNIVERSITY HOSPITAL**
**TRANSFER OF CARE FORM**
**(PRE-PROCEDURAL CHECKLIST)**

Page 1 of 2

**TUH-353, REV. 4/11**

**S**

**TO BE FILLED OUT BY RN WITH EACH TRANSFER FROM PATIENT CARE AREA**

Admitting Diagnosis:

Procedure/Test: ___________ Date: ___________ Time: ___________

(This form is valid for 24 hours) revised 1/10

**B**

**SHADED PORTION IS COMPLETED FOR ALL TYPES OF PATIENT TRANSPORTATION**

**ARMBAND VERIFICATION:**

- Identification Band on and correct
- Allergy Band
- N/A

**CODE STATUS:**

- FULL
- DNRCC
- DNRCC-ARREST

**ISOLATION:**

- N/A
- AIRBORNE
- DROPLET
- CONTACT

**ORIENTATION X 3:**

- YES
- NO

**WEIGHT BEARING STATUS:**

- FULL
- NWB to ___________
- Other:

**TRANSPORT NEEDS:**

- Wheel Chair
- Stretcher

**ASSIST FOR TRANSFER:**

- minimum
- moderate
- maximum

- # persons needed: ______

- Fall Risk Level: 1 2 3

**SPINE PRECAUTIONS:**

(Describe if applicable)

**SPECIAL NEEDS:**

- Hearing
- Language
- Vision
- O2 __ L
- IV
- Saline lock
- Restraints
- Sitter
- Telemetry
- CMU

**NOTES:**

**NURSE'S NAME:** ___________________________

**PHONE:** ___________________________

**VERBAL REPORT GIVEN TO:** ___________________________

**CREDENTIALS:** ___________________________

**DATE/TIME:** ___________________________

**INITIAL WHEN SECTION IS COMPLETE**

In addition, complete this section for Invasive Procedures.

Verbal report must be called prior to transport to an Invasive Procedure Area and/or if patient is in isolation, has had a change in their baseline status, a report must also be called to a Non Invasive Areas.

**DESTINATION:**

- OR
- Interventional Radiology
- Cardiac Cath Lab
- EP Lab
- ENDO
- Angio
- TEE
- Dialysis/Apheresis

**COMPLETED CONSENT ON CHART**

(w/ valid date, signature, & credentials)

- Yes
- No, notified

**MD/time**

**DO NOT TRANSPORT TO OPERATING ROOM WITHOUT VALID CONSENT**

**A**

**SEND PATIENT CHART WITH**

(1) Yes

(2) No, notify MD/time: ___________

- Registration Information
- Patient History
- Nursing Assessment
- Lastword Medication Report
- Bedside Flow Sheets
- MARs
- Addressograph

**PRE-PROCEDURE TEST DONE:**

(check all that apply)

- N/A
- T&S
- Blood available
- Pregnancy Test
- CBC
- Renal
- Coags
- Dentures removed
- Jewelry removed
- Hair pins
- Glasses/Contacts lenses removed
- Hearing aide
- Prosthesis removed
- IV/Saline LOCK PRESENT & PATENT:

- If not, what is the plan:

- INVASIVE and NON INVASIVE MONITORING DEVICES:

- DRAINS
- CATHETER

- ICP/Pacemaker:

- A LINE
- NG
- TF
- CT
- OTHER

*Vendor Information attached to the chart/ refer to the ICD/Pacemaker check list*

**NPO STATUS MAINTAINED SINCE:**

**PRE OP MEDICATIONS**

**VITAL SIGNS PRE-TRANSFER:**

- Time
- Temp:
- HR:
- RR:
- BP:
- ALS:
- SLS:
- SPO2:
- FSBS (if applicable)
- HT:
- WT:
- kg/lb.

**LOCATION OF PATIENT BELONGINGS:**

- Kept in room #:
- Other:

**FAMILY CONTACT:**

- Name:
- Location:
- Phone:

**EQUIPMENT SENT WITH PATIENT:**

(1) Compression boots/pump
(2) Infusers
(3) Trapeze
(4) Air mattress
(5) Bed
(6) Other:

**I HAVE REVIEWED THE PATIENT'S CONDITION AND CHECKLIST AND AGREE THE PATIENT IS PREPARED FOR THE PROCEDURE.**

**SIGNATURE:**

**CREDENTIALS:**

**DATE/TIME:**

**ON RETURN**

**CONDITION NOTES:** (To be completed by procedure area staff except for invasive procedures which requires verbal report and or if pt. is in isolation, has had a change in their baseline status, report must be called)

- No change in condition
- Other:

**RECOMMENDATIONS GIVEN:**

**VERBAL REPORT GIVEN TO:**

**CREDENTIALS:**

**DATE/TIME:**
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<tr>
<th>Prior to leaving Patient Care Area:</th>
<th>Upon Return to Patient Care Area:</th>
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<td><strong>Trip 2</strong></td>
<td>Condition Notes:</td>
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<td>☐ No change ☐ Change in condition (see progress notes)</td>
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<tr>
<td>Planned procedure:</td>
<td>☐ Equipment returned with patient</td>
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