Peter MacCallum Cancer Centre

INTERHOSPITAL PATIENT HANDOVER FORM

WRITE PATIENT DETAILS OR AFFIX PATIENT LABEL

Surname: _____

Given Names: _____

Unit Number: _____

Date of Birth: _____

Please note: Fax the form to receiving hospital prior to patient transfer. A copy should accompany the patient and the original form should be filed in the patient medical record.

Pre-Transfer & Arrival Checklist

To be completed by the nurse caring for the patient immediately prior to transfer and the nurse accepting the patient handover on arrival.

Before Departure Check	**Please ☑**
Patient is wearing Patient ID arm band +/- Alert band?	☐ Yes
Patient's most recent vital signs are recorded on this chart?	☐ Yes
Patient's observations are within the white zone/safe limits?	☐ Yes
Patient's resuscitation plan is documented?	☐ Yes
Clinical handover has been provided to the receiving hospital?	☐ Yes
All required documentation, including legal orders, are ready to travel?	☐ Yes
Patient and family are aware of transfer destination and reason?	☐ Yes
Has the Patient had the opportunity to toilet prior to leaving?	☐ Yes
Has Patient been offered PRN analgesia/anti emetics if required?	☐ Yes
Essential medications including PRNs are ready to travel with patient?	☐ Yes
Clinical handover has been provided to staff transporting patient?	☐ Yes

Patient is safe for transfer if ☑Yes to all of the above. If no: refer to Nurse in Charge.

Signature /designation:……Date:…../……/….Time:……..

(Signature of Nurse completing the pre-departure observations and checklist)

On Arrival Check

Patient has been welcomed, introduced and a 3 point ID made?	☐ Yes
Clinical handover has been provided by the sending hospital?	☐ Yes
Has the medication chart been reconciled?	☐ Yes
Has the resuscitation plan been acknowledged?	☐ Yes
Patient's observations are within the white zone/safe limits?	☐ Yes

If No: follow procedure for prompt clinical review or Met Call

Signature / Designation:……Date:…/…/….Time:……..

(Signature of Nurse completing the Arrival observations and checklist)

INTERHOSPITAL PATIENT HANDOVER FORM MR/80

Date		Pre-departure			Arrival		
Time							
Respiratory Rate (breaths / min)	Write ≥ 31						
	25–30						
	21–24						
	15–20						
	11–14						
	6–10						
	Write ≤ 5						
O2 Saturation (%)	98-100						
	95-97						
	93-94						
	90-92						
	87-89						
	85-86						
	Write ≤ 84						
O2 Flow Rate (L / min)	Write > 5						
	1–5						
	Room Air						
Blood Pressure (mmHg) Note Score is for Systolic BP. If systolic BP ≥ 240, write value in box	Write ≥ 220						
	210						
	200						
	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
	Write ≤ 49						
Heart Rate (beats / min) If heart rate ≥ 180, write value in box	Write ≥180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
	Write ≤ 49						
Temperature (C)	Write ≥ 39.1						
	38.5-39.0						
	38.0-38.4						
	37.5-37.9						
	37.0-37.4						
	36.5-36.9						
	36.0-36.4						
	35.5-35.9						
	Write ≤ 35.4						
Consciousness If necessary, wake patient before scoring	Alert						
	Voice						
	Pain						
	Unresp.						
Pain Score None (0) – Worst (10)	Write						

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☐ **Modifications in use**
if yes refer copy MR65 attached

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Surname: _____

Given Names: _____

Unit Number: _____

Date of Birth: _____

CLINICAL REVIEW CRITERIA
Compare to patient's baseline observations

- SpO2 90-94% and/or increase in Oxygen (O2) requirement
- Respiratory rate of 6-10 breaths per minute or 25-30 breaths per minute
- Pulse rate 50-60 or 120-130
- Systolic BP 90-100 or ≥ 180-200 mmHg
- Unexpected excessive drainage fluid loss
- New, increasing or uncontrolled pain
- BGL ≤ 3mmol/L or ≥ 20mmol/L
- Sudden or unexpected blood loss
- Temperature ≥ 38°C or ≤ 35.4°C

If any of the above criteria are met you MUST call for clinical review AND:

1. Inform the nurse in charge of the shift
2. Record observations at 30 minute intervals
3. Document action taken in the progress notes
4. If clinical review not attended within 30 minutes - Repeat clinical review call. Non attendance on 2nd call requires escalation to the registrar or fellow.

MET CALL CRITERIA
The following clinical signs are indicators for a MET call:

- Threatened airway - impending obstruction
- Difficulty speaking or Respiratory distress
- Respiratory rate > 30 or < 6 per minute
- Arterial oxygen saturation < 90% on supplemental oxygen
- Systolic BP < 90mmHg
- Heart Rate > 130 or < 50
- Seizures
- Altered conscious state
- Urine Volume < 0.5ml/kg/hr for 2 consecutive hours
- Concern for any other reason, including unavailability of parent unit and/or need for urgent assistance.

REFER TO THE RESUSCITATION MANAGEMENT PLAN MR63D

All emergencies dial 3333

GENERAL INSTRUCTIONS

» You must record appropriate observations:
  - On admission
  - At a frequency appropriate for the patient's clinical state.

» You must record a full set of observations:
  - If the patient is deteriorating or an observation is in a shaded area
  - Whenever you are concerned about the patient.

» When graphing observations, place a dot (·) in line with the corresponding value of the box which includes the current observation in its range of values and connect it to the previous dot with a straight line. For blood pressure, use the symbol indicated on the chart.

» Whenever an observation falls within a shaded area, you must initiate the actions required for that colour, unless a modification has been made (refer to copy of MR65 attached).

» If observations fall within both purple and orange coloured areas for the same time period, the actions required for the purple area apply.

INTER-HOSPITAL PATIENT TRANSFER FORM

Identify

Transfer discussed with patient Yes ☐ No ☐

Date of transfer

Indigenous status (circle)
A / TSI
ATSI / Unknown

Medicare no. _____

Pension / DVA no. _____

Private health insurance (PHI) fund
_____

PHI no.

(Affix patient label here)
Referring facility URN

Surname Given names

Address

Postcode DOB

Gender Male ☐ Female ☐

Allergies Nil known ☐ Yes ☐ (if yes list type, reaction and severity) Signature

General practitioner Yes ☐ No ☐ Unknown ☐

GP name_____

GP phone no. _____

GP notified of transfer Yes ☐ No ☐ Unknown ☐

Next of kin (NOK) / Carer / Substitute decision maker (SDM) (Circle)

Name _____

Phone no. _____

Relationship to patient_____

NOK / Carer / SDM notified of transfer Yes ☐ No ☐

Referring / authorising practitioner name

_____

Referring unit _____

Referrer phone/pager no. _____

Referrer position (Consult / Reg / HMO / GP / RN / Other)

Referring ward

Name _____

Phone no._____

Patient living arrangements

Living independently ☐

Residential facility ☐

In-home support ☐

Situation

Principal diagnosis / problem

Reason for transfer

Medical history / comorbidities

Observations at time of transfer: Refer observations page 3

Respiratory management plan / O_2 requirements

$Sp0_2$ target O_2 rate O_2 device

*If ETT - record any difficulty with intubation

Intravascular access Site and date of insertion

☐ No access
☐ Peripheral venous line (1) .....
☐ Peripheral venous line (2) .....
☐ Peripheral venous line (3) .....
☐ Central venous line .....
☐ Other .....

IV fluids Yes ☐ No ☐

Mental / cognitive / behaviour

☐ No issues
☐ Cognitive impairment ☐ Post-traumatic amnesia
☐ Verbal aggression ☐ Delirium
☐ Physical aggression ☐ Sleep disturbance
☐ Resistive to care ☐ Dementia
☐ Absconding risk ☐ Depression
☐ Wanderer ☐ Acquired brain injury
☐ Harm to self ☐ Harm to others
☐ Other _____

Current cognitive state _____

Glasgow Coma score

Legal status

☐ Not applicable
☐ Voluntary patient ☐ Involuntary patient
☐ Forensic patient ☐ Security patient

Nutrition and swallowing

Fasting: Yes ☐ No ☐

Time of last intake_____

Diet: Normal Diabetic Renal Soft
Puree Minced NBM

Fluids_____

Supplements _____

Restrictions _____

Safe swallow strategies:_____

Medication Crushed ☐ Whole ☐

Enteral feeding NG ☐ PEG ☐

Regime and feed sent Yes ☐ No ☐

Dentures Yes ☐ No ☐

Weight

Continence

☐ No issues
☐ Faecal continence
☐ Urinary continence
☐ Indwelling catheter
☐ Intermittent catheter
☐ Stoma / colostomy

Time last voided

Date bowels last opened

Date IDC inserted

Communication

Interpreter required
No ☐ Yes ☐

Primary language spoken

02/13

INTERHOSPITAL PATIENT HANDOVER FORM

MR/80

Background

Patient transfer form

Facility name **Date**

Specialty-specific information

(Affix patient label here)
Referring facility URN

Surname Given names

Address

Postcode DOB

Gender Male ☐ Female ☐

Alerts – none ☐ _____
Alerts – bariatric patient ☐ _____
Alerts – falls risk ☐ _____
Alerts – infectious risk ☐ _____
Alerts – pressure injury risk ☐ _____
Alerts – smoker ☐ _____

Advance care directives Yes ☐ No ☐ Unknown ☐

NFR / limitation of medical treatment order
Yes ☐ No ☐ Unknown ☐

Alerts – other:

Accompanying Pt.

Personal items	N/A	Accompanying patient	Sent with family
Clothing	☐	☐	☐
Glasses	☐	☐	☐
Dentures	☐	☐	☐
Hearing aid	☐	☐	☐
Medications	☐	☐	☐

Equipment _____

Valuables ☐ ☐

List valuables_____

_____

Other

If an air-ambulance transfer, luggage has to be less than 5 kgs

Patient ID band on patient Yes ☐

Attached copy of : (where applicable)

Doctor's letter	☐	Cognitive assessment tool	☐
Allied health letter	☐	*Advance care directives	☐
Observation chart	☐	Nursing care plan / pathway	☐
Medications chart	☐	Fluid balance chart	☐
IV orders	☐	Behaviour management plan	☐
Wound chart	☐	*Involuntary treatment order	☐

*NFR / limitation of medical treatment order ☐

Investigation results: X-rays ☐ ECG ☐
Pathology report ☐

Other

* Where these exist, a copy **must** accompany the patient

Responsibility

Receiving facility (RF)

Appropriate time for transfer agreed Yes ☐ No ☐

RF name

RF ward name

Acceptance by receiving medical practitioner Yes ☐ No ☐

Date Time

Receiving medical practitioner / unit name

_____

Receiving practitioner / unit phone no. and pager

Acceptance by receiving facility bed coordinator Yes ☐ No ☐

Date Time

Receiving bed coordinator name

_____

Receiving bed coordinator phone no. and pager

Treating allied health contact details (if applicable)

Discipline	Name	Pager/phone	Discipline	Name	Pager/phone
Occupational therapist			Dietitian		
Physiotherapist			Social worker		
Speech pathologist			Other		

Form completed by (print name and job designation) :

Signature:

Patient **transport provider (TP)** service name _____ Date and time booked

Handover received Yes ☐ No ☐ Accompanying items received Yes ☐ No ☐

Receiving transport provider name (print) Signature

Handover provided: by referring staff Yes ☐ No ☐ by TP Yes ☐ No ☐ Accompanying items provided Yes ☐ No ☐

Receiving clinical staff name (print) Signature

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