Hôpital Régional de Pembroke Regional Hospital

TRANSFER OF ACCOUNTABILITY COMMUNICATION TOOL – NURSING

Addressograph

S Situation

CPR – Plan of Care: ❑ Full Code ❑ Not discussed ❑ DNR

Physician notified of admission / transfer: ❑ YES ❑ NO

Next of kin notified of admission / transfer: ❑ YES ❑ NO

Home medications sent with patient: ❑ YES ❑ NO **Home medication bag number:**

B Background

Diagnosis:

Allergies: ❑ YES ❑ NO

Isolation:
❑ Airborne ❑ Contact ❑ Droplet ❑ OTHER:

❑ Failed ARI ❑ Loose Stool
❑ MRSA ❑ CDIFF ❑ OTHER:

Violence Risk: ❑ YES ❑ NO VAAC Complete: ❑ YES ❑ NO Care Plan in Place: ❑ YES ❑ NO

A Assessment

Most recent VS: Time: T: P: R: BP:

O_2 Sats: %O_2 at: Blood Glucose:

PAIN: ❑ YES ____/10 ❑ NO

MOBILITY:
❑ Independent
❑ Mechanical lift
❑ Bedrest

TRANSFER WITH ASSIST OF:
❑ 1
❑ 2

MOBILITY AIDS SENT WITH PATIENT:
❑ Yes
❑ No

FALL RISK:
❑ High
❑ Low

PERIPHERAL PULSES:
❑ Present x4
❑ Absent: ___________________

NEURO:
GCS: _____________
NIHSS: ____________
❑ Alert & oriented
❑ Confused

REQUIRES:
❑ Sitter
❑ Restraints: ___________________

DELIRIUM: CAM
❑ Negative
❑ Positive

RESPIRATORY:
❑ Normal
❑ Labored
❑ Distressed
❑ O_2 Therapy: ___________________
Notable on chest assessment: ___________________ ___________________

CARDIAC:
❑ Continuous cardiac Monitor
❑ Telemetry
❑ Rhythm: ___________

COLOUR:
❑ Within Normal Limits
❑ Other: ___________________
❑ Edema
Location: ___________________

SKIN:
❑ Intact
❑ Incision
❑ Dressing

BRADEN SCALE:
❑ Complete
❑ Not complete

GU: CONTINENT:
❑ YES
❑ NO
❑ Catheter
Type: _____________
Size: _____________

GI: CONTINENT:
❑ YES
❑ NO
Last BM: _____________
❑ PEG
❑ PEJ
❑ Colostomy
❑ Ileostomy
❑ Other: __________

DRAINS:
❑ NG
❑ Chest tube
❑ VAC
❑ Other: __________

DIET:
❑ NPO
Diet: _____________

LAST ANALGESIA:
Time: ____________
Dose: ____________
Route: ___________
❑ Epidural
❑ Regional block

BRACELETS APPLIED:
❑ Identification
❑ Allergy
❑ VAAC
❑ Fall Risk

ASSISTIVE DEVICES:
❑ Glasses
❑ Dentures
❑ Hearing Aids
❑ Other: ___________________

IV	Fluid Type	Rate
❑ Central ❑ Peripheral		
❑ Central ❑ Peripheral		

R Recommendation

Care to be provided within 30 minutes of arrival:

Other:

Abnormal Lab Value:

Inpatient medications sent: ❑ YES ❑ Not available

Belongings sent: ❑ YES ❑ NO **with:**

Transfer from: **To:**

Print Name (sending):	**Signature:**	**Date:**	**Time:**
Print Name (receiving):	**Signature:**	**Date:**	**Time:**