PATIENT TRANSFER CHECKLIST

TRANSFERRING A PATIENT?
PLEASE COMPLETE THIS CHECKLIST FORM – ITEMS TO FOLLOW PATIENT
THANK YOU!!!

☐ Chart
☐ MARs/IVARs
☐ Nurses Notes
☐ Transfer Form
☐ Patient Specific Medications (from tower and refrigerator)
☐ Old Chart
☐ Reduced Charts
☐ Patients Personal Belongings
☐ Kardex
☐ Notify all of the Patients Physicians of Transfer
☐ Nursing Care Plan/Clinical Pathway

______________________________
Nurse / Unit Secretary Signature
**Nursing Transfer Summary**

**Diagnosis** ____________________ Transferred from: __________ To: _______ Date/Time: __________

List attending/Consulting physicians notified of transfer: ____________________________________________

Reduced and/or old chart transferred: ☐ Yes ☐ No Family notified: Yes ☐ No ☐ Who: ____________________________

No ☐ If no, why? ____________________________

Summary of Progress: ____________________________________________________________

________________________________________

________________________________________

________________________________________

Special Instructions: ____________________________________________________________

**ITEMS TRANSFERRED WITH PATIENT:** Meds/IV Meds/IV’s MARS IVARS Kardex Tube Feeding TPN
Nurses Notes/Pathways Patient Education Folder Equipment (i.e. RT supplies, ostomy supplies, etc)

**PATIENT ASSESSMENT**

<table>
<thead>
<tr>
<th>ID Bracelet Intact</th>
<th>Allergy Bracelet Intact:</th>
<th>Yes</th>
<th>N/A</th>
<th>Isolation:</th>
<th>Yes</th>
<th>Type:</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>B/P _______________</td>
<td>P _______________</td>
<td>R _______________</td>
<td>Temp _______________</td>
<td>BG _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV: No</td>
<td>Yes</td>
<td>IV Solution Rate</td>
<td>IV Solution Rate</td>
<td>Vol. Remaining</td>
<td>Vol. Remaining</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Intake: PO</td>
<td>Parenteral</td>
<td>Current Output</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Epidural Pump/Drug ____________________________________________________________

PCEA/PCA Dose ________ | Lockout ________ | Basal Rate ________ | One H Limit ________ | Vol. Remaining ________

Method of Transportation: Wheelchair Stretcher Bed Accompanied by: ____________________________

Cardiac Status:________________________

GU Status: ____________________________

Respiratory Status: ____________________________

GI Status: ____________________________

Nutrition: Diet _______________________/TPN/NPO

Skin: Appetite: ____________________________ Last Stool: ____________________________

Mark any unusual skin conditions present on transfer:

1. Surgical Wounds
2. Rash
3. Eczymosis
4. Skin Tears
5. Pressure Ulcers

Sacrum: ☐ red/pink/purple non–blanchable erythema
Buttocks: ☐ heels – R / L; sacrum/buttocks – R / L
Skin tears/blisters/abrasions

Excoriation/incontinence

Stage 2, 3, 4 wounds/decubitis

Dentures: ☐ upper ☐ lower ☐ partial
Glasses: ☐ Contacts: ☐
Hearing Aid: ☐
Wheelchair: ☐ Crutches: ☐ Walker: ☐
Cane: ☐ Prothesis: ☐
Personal Items ____________________________

RN/LPN Signature: ____________________________ Date: ____________________________

Dev 12/00
Rev 2/02
NSG00037
Receiving Nursing Unit

Date/Time Received: ______________________________

ITEMS TRANSFERRED WITH PATIENT: ☐ Meds/IV meds/IV’s ☐ MARS ☐ IVARS ☐ Kardex ☐ Tube Feeding ☐ TPN
☐ Nurses Notes/Pathways ☐ Patient Education Folder ☐ Equipment (i.e., RT supplies, ostomy supplies, etc)

Dentures: ☐ upper ☐ lower ☐ partial ☐ Glasses ☐ Contacts ☐ Hearing Aid
☐ Wheelchair ☐ Crutches ☐ Walker ☐ Cane ☐ Prosthesis _________________________________________

☐ Wallet/Purse ____________________________________________ ☐ Jewelry _____________________________________________
☐ Clothes ________________________________________________ ☐ Other _______________________________________________

Reduced and/or old chart transferred: ☐ Yes ☐ N/A ☐ Sent by: _____________________________________________ Signature

Oriented to Nurse Call/Room Environment: ☐ Yes ☐ No If no, explain: ___________________________________________

PATIENT ASSESSMENT

B/P _______________________   P ____________________   R ____________  Temp ___________    B/G _______________

☐ No IV IV’s intact without redness or swelling ☐ Yes ☐ No If no, explain _______________________________________

Epidural/PCA Pump – Drug ___________________________________________________________________________________________

PCEA/PCA Dose _______   Lock out ______  Basal Rate ______  One H Limit _______  Vol. Remaining _________

Cardiac Status:                                                                                          GU Status:

Respiratory:                                                                                               GI Status:

Neuro Status:                                                                                              Skin:

RN/LPN Signature: _____________________________________________ Date: __________

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