Queensland Government

Gold Coast Health

CLINICAL HANDOVER TRANSFER

Facility: _____

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

The CH Transfer Form will be completed for adult inpatient admissions / transfers with reference to the CH Policy (POL1581). To be completed in 2 stages: 1. **Phone to phone handover** between admitting person and receiving wards; 2. **Face to face** handover at the bedside on arrival to the ward.

IDENTIFICATION

Patient details confirmed: ☐ Y

SITUATION

Transfer Date: / /

Consultant:

Pt / NOK / Carer notified: ☐ Y ☐ N

Specify:

Provisional Diagnosis:

BACKGROUND

☐ Advance Health Directive

☐ Acute Resuscitation Plan

Alerts:

☐ Mental Health Status: ☐ Voluntary ☐ Involuntary

Allergies: Medication / Food

Infection / Precautions:

Relevant Clinical Hx:

ASSESSMENT (tick all that apply)

☐ QADDS ☐ CARDIAC QADDS ☐ ED QADDS ☐ **SCORE =** **TIME:** ____:____

Modifications: ☐ Y ☐ N ***If Y tick below:***

☐ Chronic Abnormal Physiology ☐ Temporary Modifications

☐ RR ☐ O_2 Sats ☐ O_2 Flow Rate ☐ Systolic BP ☐ Heart Rate

☐ MET CALL (for this episode)

☐ ED MET CALL Criteria

Date: Time:

Reason:

FALLS RISK: ☐ At risk ☐ Not at risk TED stockings : ☐ Y ☐ N

MOBILITY: ☐ Independent ☐ Supervision ☐ AIDS ☐ 1xA ☐ 2XA

Smoker: ☐ Y ☐ N

Pressure Injury: ☐ Y ☐ N Present on Admission: ☐ Y ☐ N

Wound: ☐ Y ☐ N Location: _____ Diet: _____

Nutrition: Malnutrition Risk ☐ Y ☐ N Dysphagia ☐ Y ☐ N NBM ☐ Y ☐ N

Interventions / Investigations completed:

Invasive Devices Log:

☐ Y ☐ N

☐ IDC ☐ PICC

☐ IVC ☐ CVL

Other:

RECOMMENDATION

Medication Charted: ☐ Y ☐ N PRN orders: ☐ Y ☐ N VTE Risk: ☐ Y ☐ N Pts Own meds: ☐ Y ☐ N

Communication / Language: ☐ English ☐ Other Interpreter: ☐ Y ☐ N

☐ EMR updated Referrals: _____

Investigation / Procedures to be completed: _____

_____

Valuables / Belongings: ☐ Wallet ☐ Glasses ☐ Dentures ☐ Phone ☐ Clothing ☐ Shoes ☐ Keys

PHONE HANDOVER		BEDSIDE HANDOVER ON ADMISSION	
FROM: _____	TO: _____	FROM: _____	TO: _____
Name: _____	Name: _____	Name: _____	Name: _____
Signature: _____	Signature: _____	Signature: _____	Signature: _____

DO NOT WRITE IN THIS BINDING MARGIN

Do not reproduce by photocopying

All clinical form creation and amendments must be conducted through Health Information Services

Date Reviewed – 05/2018

00050:GC10524

CLINICAL HANDOVER TRANSFER

Figure 1. Checklist developed