GRAND RIVER HOSPITAL
Advancing Exceptional Care

TRANSFER OF INFORMATION TOOL

Patient Name:_____

S

Primary Diagnosis: _____
Isolation: □Yes □No □ Airborne □ Droplet □ Enhanced Droplet □ Contact □ ContactPlus □Bedspace
ARO Swabs completed: □yes □no
Allergies: □ NKA □ Yes:_____
Designated Level of Care (Code Status): □ Full Code (Full Medical Care) □ DNR □ Not addressed
Language barrier: □ yes □ no Language spoken: _____
Sending Facility: _____ □ Other _____
Medications: □ BPMH complete

B

Relevant Past Medical/Surgical Hx:

IV/Other Lines: Solution/Rate/Site_____

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Mobility: □ Falls Risk □ Bedrest □ Assist □ 1 person □ 2 person Aides: □walker □wheel chair □ hoyer
□ Home Care involved Diet:

A

* Review and complete each Assessment section. If not applicable, stroke a diagonal line through the section to indicate it has been reviewed.*

Time of last VS:_____ TPR _____ BP_____ O_2 sat % _____

Respiratory: O2_____	Cardiovascular: □ Cardiac Monitor	Neuro: □ oriented □ confused
Gastrointestinal: □ NG tube	Renal/Urinary □ Hemo □ PD Catheter □yes □no	Skin/Wounds:
Reproductive:	Musculoskeletal:	EENT:
Psychosocial/Family Situation: Mental Health: □ Form 1 □ Form 3 □ voluntary	Pain:_____/10	Endocrine: □ Diabetic □ BG last taken_____

R

Medications/Treatments/Pending Labs/Diagnostics due within 60 minutes of arrival to floor:

D

Sending:
Name:_____
Signature:_____
Phone Number/ Unit Ext:_____
Date/Time:_____

Receiving:
Name:_____
Signature:_____
Date/Time:_____

Sent with patient:
□ Meds from pharmacy
□ Meds from home
□ Meds from fridge
□ Dentures □ Glasses
□ Hearing Aid
□ other_____

Facility notified of transfer □ yes □ no
Family notified of transfer □ yes □ no
Family received privacy code □ yes □ no

Safety Checklist

	1p	2p
ID confirm		
Armband		
IV		
Restraint		
Allergies/alert		
Alarms		

Method of Transfer:
EMS
Transfer Service
Self Transfer

Do NOT Fax this form. The nurse should call in the TOI report to the nurse receiving the patient