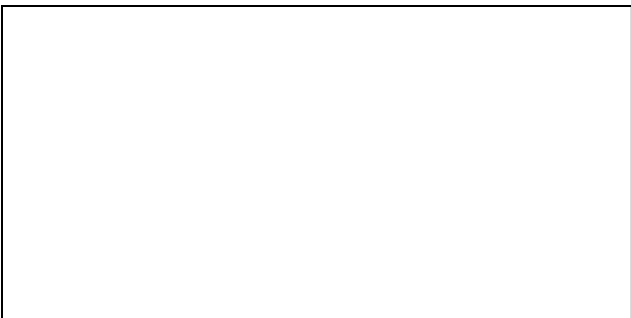


PRCC Patient Hand Over Tool

The purpose of the document is to facilitate the communication of patient information in order to ensure that the receiving healthcare provider has the appropriate information to safely care for the patient over the next 3-6 hours.



Name: _____ ID#: _____ DOB: _____

Sending Facility: _____ Contact #: _____ (if more information is required)

Arrival time at PRCC: _____ Date: _____

To be completed by the sending facility for each visit
Please send with patient OR fax back to (905) 813 4168 before the appointment date.

Information to be sent with patient:

- Chart & MAR
- Armband & photo ID
- All required medications including PRN
- CDs and films as requested

Code status No CPR full code N/A

Vital signs normal & or stable No Yes (refer to vital signs sheet)

Allergies & armband: No Yes (refer to chart)

Isolation: No Yes Type: _____ (inform ahead for isolation)

Oxygen required: No Yes FiO²: _____ L/min: _____

Ambulatory: Self Assist device 1 assist 2 assist Transfer board

Pain scale : _____ /10

Mental status: Alert & oriented Confused

Diabetic: No Yes (if yes please supply food)
Time of last meal: _____ Insulin last given at: _____

Pacemaker No Yes (if yes please send details of make & model)

Sending staff signature: _____ / Receiving staff signature: _____

Transfer to Radiation Therapy

Ambulance transfer record present

Return transfer confirmed Time of return: _____

To be completed at Prep desk

Machine _____

Doctor _____

No CPR acknowledged by MRP Signature of RT: _____ Date: _____

Comments/:

Other relevant information: