RN TO RN HANDOFF TOOL

SITUATION	**BACKGROUND**	**ASSESSMENT**	**RECOMMENDATIONS**
Identifying Information	***What patient information relates to what is going on now?***	***What is the patient's overall condition?***	***What is the recommendation for patient care planning?***
1. Name, gender, age, room # **2. MD, Diagnosis** **3. Code status, Allergies**	**4. Relevant past history/comorbidities** **5. History of hospital course, tests, procedures** **6. Medications related to problem/concern** **7. Standards or Precautions:** Fall, Seizure, HOH, Lang Barrier, Isolation, Sitter, Restraints, Aspiration, Skin/Wnd **8. Altered findings:** Neuro, CV, Resp, GI/GU, Skin/Wnd, Lines, Tubes, Fluids, Blood Transf, VS, Pain, Labs, XRay	**9. What are your concerns?** **10. What have you done about them?** **11. Have the interventions been effective?** **12. Priority Nursing Diagnosis** **13. Is the patient *STABLE* or *UNSTABLE*?** **14. Expected Discharge Date** **15. Barriers to Discharge:** Pain, Mobility, Skin, Inf, Oth	**16. Goals for patient stability** Pathophysiology, Psych, Behavioral, Cognitive, Social, Spiritual **17. Plan for care** include surgery or procedural preparation **18. Care Coordination** PT, OT, Speech, MSW, Respiratory, Neuropsych, Respiratory, Case Management **19. Teaching/Discharge Plan** **20. Any other questions or concerns**
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