



**Shift Hand-Off Communication\***

<b>D</b>	<b>Pt. Name:</b> <b>New allergies:</b> <b>History of current illness:</b> <b>Significant past history:</b>	<b>Transferring to:</b>
<b>A</b>	<b>Abnormal assessment findings:</b>  <b>Significant recent lab or test results:</b> <b>Functional ability/activity:</b> <b>Diet (if changed):</b> <b>Pain assessment/reassessment need:</b> <b>Psychosocial/family/teaching needs:</b> <b>Resuscitation status (if not full code):</b>	
<b>T</b>	<b>Scheduled procedures or surgeries:</b> <b>Current interventions:</b>  <b>Invasive lines and therapies:</b>  <b>Pending tests or treatments and anticipated action:</b>	
<b>A</b>	<b>Plan for next care cycle or discharge plan (as applicable):</b>  <b>Consults or physician follow-up:</b>  <b>Interventions to be completed:</b>	



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