

HANDOVER TOOL
FOR INPATIENT and DAYPATIENT

To be completed in pen by a health care professional 48 HOURS prior to patient transfer. Please print legibly.

Date completed: _____ Date of admission to HBKRH: _____

NAME OF CLIENT:

Surname Given Initial Preferred Name/Nickname

Brain Injury Rehab Team Specialized Orthopaedic Developmental Rehab Complex Continuing Care

A. MEDICAL HISTORY/PHYSICIAN SECTION

HOSPITAL COURSE (updates since initial referral):

Please complete box below ***only*** if patient has any physician ordered mobility restrictions and/or wound care:

Had orthopaedic surgery with pre-booked Bloorview bed – Ensure 1 page post-op d/c order form has been completed

Other –Physician to complete rehab orders below and sign:

Weight Bearing Status: RIGHT Upper/Lower Extremity LEFT Upper/Lower extremity

Non WB Touch WB Partial WB WB as tolerated **Duration** of WB restriction: _____ x weeks

Activity Restrictions:

ROM as tolerated: yes no *precautions:* _____

Active ROM: yes no *precautions:* _____

Passive ROM: yes no *precautions:* _____

Strengthening/Resistance training permitted: yes no *precautions:* _____

Please indicate any other precautions/contraindications to therapy or patient care:

Orthoses/Bracing/Stockings/Garments:

Neck Trunk Upper extremity: L or R Lower extremity: L or R

Specify type (TLSO, Jewitt, AFO, etc.): _____

Wear Recommendations: wear at all times wear when upright off in bed (HOB angle below _____)

Wear for any weight bearing/mobilizing Wear for transportation only

Other wear recommendations: _____

Recommended interventions (i.e. hydrotherapy, traction, splinting etc): _____

Wound Care: Required Not required

Dressing Materials/Type: _____ *Dressing Frequency:* _____

Physician Signature: _____ **Date:** _____



FOLLOW-UP PLANS: complete below OR see attached

Follow up Blood work required: Yes No Schedule: _____

Radiation and/or Chemotherapy Schedule: _____

FOLLOW-UP CLINICS BOOKED:

Name: _____ Time: _____ Tel: _____ ext _____
Name: _____ Time: _____ Tel: _____ ext _____
Name: _____ Time: _____ Tel: _____ ext _____

MEDICAL/SURGICAL FOLLOW-UP PLAN

Staff Person: _____ Follow-up Clinic: _____ Date: _____
Staff Person: _____ Follow-up Clinic: _____ Date: _____
Staff Person: _____ Follow-up Clinic: _____ Date: _____
Future Surgery: _____ Date: _____
Future Imaging: _____ Date: _____

B. NURSING SECTION

Allergies (drug, food, latex, etc.) _____

Medications See attached Medication Profile (or complete below)

CURRENT MEDICATIONS State medication, dose and helpful hints. Highlight unusual medications e.g. chemo.				
Drug	Dose	Frequency	Route	Length of Rx

DOES THE FAMILY HAVE HEALTH BENEFITS: Yes No Unsure

SECTION 8 REQUIRED: Yes No Application Completed: Yes No

Immunizations Up to Date: Yes No Had Chicken Pox: Yes N Vaccination

Current season's influenza vaccine Yes No Contraindicated (state reason): _____

Isolation Precautions: Yes No Explain: _____

PAIN MANAGEMENT

Pain Medications: _____ Adjuncts: (i.e. Advil, Valium) _____

Frequency of administration in last 24-48hours: _____ Pain Assessment Tool: _____

Non-pharmacological/distraction techniques: _____

Any aggravating factors: _____

MOST current lab reports (Blood, X-ray, i.e. MRI, CT Scan e.g.) **Attached**

Skin Integrity/Breakdown/Pressure Ulcer

Location: _____



Wound Care/ Dressings

Location: _____

Instructions for Care: _____

MEDICAL ASSISTIVE TECHNOLOGY

Any Changes: Yes No Describe: _____

Describe any other Supplies/Equipment required: _____

SEIZURE ACTIVITY Yes No

Describe: _____

GLASGOW COMA SCALE: ____/15

SENSORY

Vision

Adequate Impaired Describe: _____ Glasses Yes No

Comments: (e.g., blurry vision, eye patch) _____

Hearing- (with aid, if worn)

Adequate Impaired Deaf Hearing Aid

Level of consciousness

Alert Lethargic Comatose

Comments: (e.g. reduced endurance, ability to attend)

FAMILY EDUCATION: What is the family doing with the child now?

PROM/ Stretching Exercises Walking Transfers Home/Ward programs

Feeding CPR Seizure management Other Program _____

C. NURSING/NUTRITION/OCCUPATIONAL THERAPY SECTION

ACTIVITIES OF DAILY LIVING

Sleep

Sleeps most of the night Awakens frequently Naps required

Speciality mattress required: Yes No Type: _____

Type of bed _____ Sleep Position _____

Rail padding/ positional devices _____ Comments: _____

Ability to dress

Independent Needs Supervision Needs Assistance Dependent

Comment: _____

Hygiene

Independent Needs Supervision Needs Assistance Dependent

Shower bench/commode

Comment: _____

ELIMINATION

Bowel

Full Control Bowel Routine (to maintain control) Occasional incontinence

Incontinent Toilet training Commode Type

Bladder

Full Control Bladder Routine (to maintain control) Occasional incontinence

Incontinent Diaper size _____ Drainage Condom Catheter

Catheter routine (times): _____ Catheter type/size: _____

NUTRITION

Anthropometric History:

Weight History: _____

Height/Lenght: _____

Other Pertinent information: _____



Oral Feeding : Yes No Gag Reflex: Yes No
 NPO Difficulty chewing Difficulty swallowing
 Breastfed Bottle fed – feeding schedule: _____

Consistency of food
 Not safe for solids Pureed Minced/Ground Soft diet Regular
 Special Diet (*kosher, calorie reduced, etc.*)
 Comment _____

Consistency of fluids
 Not safe for liquids thin liquid nectar honey regular
 Thin puree pudding

Alternative feed method
 Gastrostomy (G) Tube G/J tube Pump Gravity
 Nasogastric (NG) tube Total Parenteral Nutrition
 Tube size/type: _____ Formula: _____
 Volume of feed: _____ Rate of Feed: _____
 Feeding schedule: _____

Video fluoroscopic feeding study completed? Yes No Please attach report or provide the date: _____
 Findings _____
 Future study: _____ Future surgery: _____

Current Feeding Recommendations: _____

D. REHAB SECTION/OCCUPATIONAL & PHYSIOTHERAPY

Mobility
 Bed rest Sits (with, without) assistance at edge of bed
 Walks with assistance X (____) persons or with (_____) describe aid
 Walks with close supervision Walks Independently

Transfers:
 Independent Requires supervision
 Requires assistance of ____ number of persons Min Mod Max (lift)

Aids/Seating
 Manual Wheelchair Power W/C
 Wheelchair type _____ dimensions/size _____
 Cushion: _____
 Stroller Type _____ Walker Type _____
 Splints Casts Collar Halo Other _____

SAFETY/SUPERVISION

Behaviour/coping patterns
 Co-operative Withdrawn
 Agitated Night time Daytime
 Aggressive Verbally Physically
 Triggers: Noise Light Frustration Pain
 Wanderer
 Comments: _____

ANY RESTRICTIONS
 Specify: _____
 1:1 Supervision Required
 Physical restraints _____
 Helmet – Wearing Schedule: _____

RANCHOS CURRENT LEVEL: Circle 1 2 3 4 5 6 7 8

Current Therapy Recommendations: _____



H. DEMOGRAPHICS

No change from initial referral

LEGAL GUARDIAN	Legal Guardian: Name: _____ Address: _____ _____	In Case of an Emergency Contact: Name: _____ _____
	Home (H) _____ (W) _____	Relationship: _____ _____
		Home(H) _____ (W) _____ _____

Hospital Contacts:

Staff Physician:

Name: _____

Tel: _____ ext _____

PT:

Name: _____

Tel: _____ ext _____

OT

Name: _____

Tel: _____ ext _____

Discharge Planners/TCC

Name: _____

Tel: _____ ext _____

Dietician

Name: _____

Tel: _____ ext _____

SW

Name: _____

Tel: _____ ext _____

SLP

Name: _____

Tel: _____ ext _____

Unit/Nurse Practitioner

Name: _____

Tel: _____ ext _____

SCHOOL INFORMATION

Home School Name: _____ Grade: _____

School address: _____

Telephone Number: _____ Teacher's Name: _____

School aware: Yes No School involved: Yes No

Community Vendors (including SickKids): _____

Contact Name (and telephone): _____

IF DISCHARGED HOME BEFORE TRANSFER TO BLOORVIEW KIDS REHAB - FILL OUT THIS SECTION:

CCAC Case Manager:

Name: _____

Priority Interim Yes No

Tel: _____ ext _____

CCAC Involvement - please describe what services have been put in place: _____

IF MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Insurance Company Name: _____ Telephone: _____

Case Manager's Name/Company: _____ Telephone: _____

Lawyer's Name/Firm: _____ Telephone: _____

