PATIENT ASSESSMENT

SHIFT REPORT + SAFE HANDOFF

PATIENT / ROOM	DATE / SHIFT	RN	AGE	CODE STATUS

ADMITTING DIAGNOSIS / CHIEF CONCERN	ALLERGIES	ISOLATION / PRECAUTIONS

LATEST VITALS

BP	HR	RR	SpO2	TEMP	PAIN	BG	O2 / FLOW

FOCUSED ASSESSMENT

NEURO
LOC / orientation / pupils / changes

RESPIRATORY
Sounds / work of breathing / oxygen

CARDIAC
Rhythm / perfusion / edema

GI / NUTRITION
Diet / abdomen / last BM / nausea

GU / OUTPUT
Voiding / catheter / I&O

SKIN / WOUNDS
Integrity / dressings / drains

MOBILITY / SAFETY
Assist level / fall risk / mobility

PAIN / SYMPTOMS
Location / severity / response

TREATMENTS & PRIORITIES

IV ACCESS / TUBES / DRAINS
IV site, access, devices

O2 / FLUIDS / DRIPS
Rate, delivery, titration and monitoring

LABS / DIAGNOSTICS
Important results and pending tests

MEDICATIONS / THERAPIES
Due, PRN or reassessment needed

WATCH ITEMS / ESCALATION
Risks, abnormal findings, when to call

TIME-BASED TASKS & REASSESSMENT

TIME	ACTION / FOLLOW-UP	DONE
		☐
		☐
		☐
		☐

HANDOFF | SBAR

S SITUATION

B BACKGROUND

A ASSESSMENT

R RECOMMENDATION

Keep patient information secure. Follow organizational policy for handling and disposal.
Working report aid only; required assessment, medication and handoff documentation stays in the EHR.