Holland Bloorview
Kids Rehabilitation Hospital

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto ON Canada M4G 1R8
T 416 425 6220 **T** 800 363 2440 **F** 416 425 6591
www.hollandbloorview.ca

Handover Tool

Complex Continuing Care

Date completed: ____________________ **Date of admission to Holland Bloorview:** ____________________

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

NAME OF CLIENT:

____________________	____________________	______	____________________
surname	given	initial	preferred name/nickname

ALLERGIES:

☐ Check when complete (for verbal report) **Section 1 – PATIENT HISTORY**

☐ **Past medical/surgical history including co-morbid conditions:** e.g. sickle cell — **See attached** ☐

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☐ **Updated history of present illness:** — **See attached** ☐

____
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☐ **Current priority patient issues:** *e.g. current issues of focus for this patient*

____
____

☐ **Resuscitation status:** — **See attached** ☐

☐ **Full Code** ☐ **DNR** ☐ **Advanced directive:** ______________________________

Section 2 - NEURO

☐ **Developmental level:**

Motor: ______________________________

Language: ______________________________

Cognitive: ______________________________

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☐ **Physical findings & relevant diagnostics:** *e.g. cognitive function, ultrasound/CT/MRI results*

☐ **Monitoring & treatment plan:**

☐ **Seizure:**
History: ____________________
Current status: ____________________

Section 3 - CARDIOVASCULAR

☐ **Vital sign trends:** T_______ P_______ R_______ BP______ Oxygen Saturation_______

☐ **Physical findings & relevant diagnostics** (*e.g. edema, pulses, cap refill, lab results, echo results)* **See Attached** ☐

☐ **Monitoring & treatment plan:**

Section 4 - RESPIRATORY

☐ **Respiratory assessment:**

☐ **Relevant diagnostics:** *e.g. blood gases, x-ray results* **See Attached** ☐

☐ **Tracheostomy:** **N/A** ☐

Type ____________________Size______________ Date of trachy insertion:____________________

Date of last trach change ____________________Frequency of trach changes:____________________

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☐ **Ventilation:** *e.g. settings, Fi02, 02 dependency, weaning plan*

Mode: ________________________ FIO2:________ Settings: ________________________

Weaning plan: ____

☐ **Suctioning:** *e.g. frequency, type of secretions, tolerance to suctioning*

Frequency________ Special precautions (e.g. two man suction) ________________________

Tolerance________________ Secretion location________________ Amount__________

Section 5 – GI/GU

☐ **Physical findings:** *e.g. abdo girth, bowel sounds, urine output, ultrasound, CT*

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____

____

Relevant diagnostics: **See Attached** ☐

☐ **Tube feeding:**

Formula: ________________________ Frequency: ________________________

Last tube change: ________________________

☐ **Nutrition:** *e.g. type, amount, route, patient tolerance, breastfeeding plan*

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☐ **Monitoring & treatment:**

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Section 6 – SKIN INTEGRITY

☐ **Physical findings** e.g. areas of concern, pressure sores **See Attached** ☐

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☐ **Monitoring & treatment** e.g. type of pressure limiting device, positioning strategies, frequency of turning, dressing's

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Section 7 – PAIN AND SEDATION MANAGEMNT

☐ **Pain/sedation assessment:** *e.g. recent pain scores, physical findings, level of sedation*

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___
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☐ **Pain/sedation management:** *e.g. patient tolerance, strategies used to manage pain*

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Section 8 - MEDICATIONS

☐ **IV access** PIV PICC CVL

Date of insertion:_________________________ size:___________________ length:____________________

Date of last dressing change: _______________________________Date/time of last heparinzation:____________________________

☐ **Medications** (*e.g. name, dose, route, frequency, tolerance)* **See Attached** ☐

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Section 9 – FAMILY CARE

☐ **Teaching completed:**

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☐ **Psychosocial needs** *(e.g., visiting plan, social work)*

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___

Report provided by: __________________________ Report provided to: _______________________

Date: ____ Time: ___________________________________

Interpreter required Y N Language:____