EMERGENCY DEPARTMENT TO INTENSIVE CARE UNIT / HIGH DEPENDENCY UNIT
NURSING HANDOVER DOCUMENT

CRITICAL CARE

EMERGENCY MEDICINE

Place patient addressograph here

Diagnosis: _____

Past Medical/Surgical Hx:

_____

_____

Adverse Events in ED:

_____

AIRWAY & BREATHING	CIRCULATION	NEURO	INVESTIGATIONS	ACCESS	PERSONAL
Self-ventilating ☐ Non rebreather 100% ☐ Venturi Mask ☐ Non Invasive ☐ Cpap ☐ Bpap ☐ Intubated ☐ Time & Date _____ ET Tube size _____ Lip level _____ Airway Grade _____ **Ventilated Patient** Ventilator mode PRVC ☐ PS/CPAP ☐ Volume support ☐ Other _____ TV Max 6mls/kg IBW ☐ Fio2 _____ PEEP _____ ABG ☐ Time ____ Cuff Pressure ____ Closed Suction ☐ Continuous Waveform Capnography ☐	Weight kg _____ Temp: _____ BP: _____ MAP: _____ RR : _____ HR: _____ Spo2: _____ BSL: _____ Noradrenaline ☐ Dosage Adrenaline ☐ Dosage **If >5mcg/kg then:** Y connector ☐ 2nd Drug syringe ☐ IV Fluids given ☐ Volume & Type _____ _____ Blood Products RCC ☐ Platelets ☐ Plasma ☐ Fibrinogen ☐ _____ _____	GCS: _____ Pupils: ☐ Time _____ Size Equal ☐ Reactive ☐ Sedation-please state _____ _____ Paralysis ☐ Drug & amount _____ Time _____ **Spinal precautions** ☐ _____ Last log roll time _____ C-collar ☐ VAC Mattress ☐ Time commenced Skin Integrity intact? ☐ If no specify: _____ _____ _____ Braden Score value _____	Blood Cultures ☐ Urine ☐ Sputum ☐ Wound swab ☐ _____ Chest X-Ray ☐ ECG ☐ Pregnancy Test ☐ Toxicology Screen ☐ Results _____ CT/MRI ☐ _____ Bloods FBC ☐ U&E ☐ COAG ☐ LFT ☐ CRP ☐ GROUP & HOLD ☐ OTHER _____ _____ TIME _____ Additional Info _____ _____	Central Line: ☐ Date & Site: Arterial line: ☐ Date & Site: Peripheral Cannula: ☐ _____ Date & Site: Chest drain ☐ site Suction **Drains** Urinary Catheter: ☐ Nasal Gastric Tube ☐ Fine bore ☐ Ryles tube ☐ Insertion date: Colostomy ☐ Ileostomy☐ Urostomy ☐ OTHER DRAINS Please specify _____	Next of Kin informed ☐ Next of KIN details in patient chart ☐ Dentures ☐ Glasses ☐ Valuables _____ **Allergies** _____ Isolation ☐ Reason _____ Transfer Events _____ _____ _____ _____ _____ _____ _____ _____ **Time admission to ICU requested** _____ **Actual time of admission to ICU** _____

Date: _____ **Emergency Nurse:** _____ **Intensive Care Nurse:** _____

Form designed by the nursing staff of the Emergency Department & Intensive Care Unit, St James Hospital.
Jan 2019