Queensland Government

Metro North Hospital & Health Service

TRANSITION CARE COMMUNITY CLINICAL HANDOVER

Facility: ☐ Community

(Complete if applicable)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Next of kin / best contact: Name: ..... Phone: .....

Confirmed hospital discharge date: ..../..../.... GP name: ..... Phone: .....

Discharge destination confirmed as: ☐ Home ☐ Other: Address: .....

Medications: **Seven day supply of medications to be organised for discharge.**

Does the client have allergies? ☐ Yes ☐ No ☐ Unknown

Are they independent with their medications? ☐ Yes ☐ No ☐ Unknown

If no, is there anyone who will be assisting the client at home? ☐ No ☐ Yes, please specify: .....

Has the client completed a self-medication trial whilst in hospital? ☐ Yes Pass/Fail ☐ No

Medication aid organised? ☐ Yes, please specify: ☐ Webster Pack ☐ Sachet ☐ Other: .....

Cytotoxic medications/precautions? ☐ No ☐ Yes, please specify: .....

Trans-dermal patches? ☐ No ☐ Yes, please specify: .....

Is the client independent with applying patches? ☐ Yes ☐ No

If No, a Medication Authority will need to be completed for nursing staff to assist.

☐ Requires administration of medications including injections/anticoagulants – *Medication Authority Form MUST be attached (Contact CRU for a copy) Medical Governance is under care of the client's general practitioner*

☐ On anticoagulants: *Monitoring, if required must be arranged prior to leaving the hospital*

Monitored by: ☐ QML ☐ S&N ☐ GP Last INR result: ..... Next INR due date: ..../..../....

Last dose: ..... Next dose: ..... ☐ Home visiting service organised

Independent with anticoagulant administration ☐ Yes ☐ No

If No, Medication Authority from required if family unable to administer

Diabetes

Is the client diabetic? ☐ No ☐ Yes, please specify: ☐ Type 1 ☐ Type 2

Are they independent with BGL monitoring? ☐ Yes ☐ No - frequency of monitoring: .....

Is client on insulin? ☐ No ☐ Yes, type: ..... Frequency of dosing and units given: .....

Have they seen by a Diabetes Educator while admitted? ☐ Yes ☐ No - follow up arranged? ☐ Yes ☐ No

Independent with insulin dosing? ☐ Yes ☐ No

If no, is there anyone at home to assist with BGL monitoring/insulin administration? ☐ Yes ☐ No

If no, Transition Care staff can only visit client daily to assist with insulin administration and a medication authority will need to be completed.

Infection status

Precautions VRE: ☐ Yes ☐ No MRSA: ☐ Yes ☐ No ESBL: ☐ Yes ☐ No CRE: ☐ Yes ☐ No

Have any recent infections required antibiotics/anti-viral therapy? ☐ Yes ☐ No

If yes, site of infection: ..... Name of antibiotic: .....

Duration of antibiotic treatment: ..... ☐ VRE ☐ MRSA ☐ Other infection: .....

Continence

Does client have a stoma? ☐ Yes ☐ No If yes, is it: ☐ New ☐ Existing

Is the client independent in managing the stoma or do they have a carer that will assist? ☐ Yes ☐ No

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Continence (cont.)

How often is the stoma needing to be changed? Please specify: .....

Does client have an: ☐ SPC ☐ Community TCP nurses not able to change SPC's, additional service will need to be organised.

Supplies will need to be sent with the client for 3 changes.

☐ Needs pads – type and size: ..... OR ☐ MASS / ☐ CAPs funded *(tick)*

☐ Needs assessment at home ☐ IDC size: .....

Date last changed: ..../..../.... Date due for change: ..../..../....

Skin integrity

Wound care required? ☐ Yes ☐ No Wound Care Plan sent: ☐ Yes ☐ No

Sites: .....

Frequency: .....

3 days of wound supplies to be sent home on discharge.

Stockings required? ☐ Yes ☐ No ☐ Permanent

☐ Temporary cessation date of stocking application: ..../..../....

Is the client independent in applying their stockings or do they have a carer that can assist? ☐ Yes ☐ No

Times to apply/ take off stockings: .....

Does the client have any pressure injuries? ☐ Yes ☐ No

Sites: ..... Stage: .....

Nutrition

Any special/modified diets? ☐ Yes ☐ No

Is the client on a fluid restriction? ☐ Yes ☐ No If yes, reason: ..... Daily limit: .....

Does the client have a PEG? ☐ Yes ☐ No

If yes, who will be caring for PEG once client is discharged: .....

.....

Type of PEG? ☐ RIG ☐ Balloon ☐ Bumper

Date inserted: ..../..../.... How was the PEG inserted? .....

Date due for replacement: ..../..../.... Where is client having it replaced? .....

PEG care required? e.g. Balloon checks, rotation of tube etc: .....

Does the client have any other special care needs? ☐ Yes ☐ No

Please specify: .....

Equipment: ☐ Yes Weight of patient: ..... kg ☐ None required on discharge

Item	Specifications e.g. height/size/weight

Name:	Signature:
Designation:	Date:

DO NOT WRITE IN THIS BINDING MARGIN