UCLA Health

6 WEST SAFE TRANSITION SHIFT REPORT

Room #	MRN: Patient Name: (Patient Label)	**Code Status:**	Admission Date:	Weight:
		Isolation:	**P**hysical Limitations: ACTIVITY/BMAT:	CCP:
		Team: Intern: Resident:	THERAPY: ☐ PT ☐ OT ☐ RT ☐ ST	
			Consults: Nutrition ☐ Spiritual ☐ Social ☐ Other ☐	
		Diet / NPO / NPO p MN:	Restraints: Vest SR/ x2 x4 Expire: Date: Time: Needs renewal : Y/N	
ALLERGY:		TUBE FEEDS:	PRECAUTIONS: FALL / ASP / SZ FALL RISK SCORE:	
Psychological/Behavioral: N: C: R: GU: GI: Skin: DSG: DRAINS:	**P**rinciple Diagnosis (**DX**/PMH/PSH): **P**rior Hospitalizations: **P**alliative Care:	Restrictions:	**BED ALARM:** ON ☐ OFF ☐ REASON OFF:	
		Dialysis access: HD days: M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ Su ☐ Fluid removed:	TESTS/PROCEDURES:	
	Patient Support: *"What is the most important thing I can do for you?"*	PIV ☐ Central Line ☐ IVF:	**STATS/NEW ORDERS/MISCELLANEOUS:**	
Labs: Labs to be drawn/ Specimens to be collected:	**VITAL SIGNS/PAIN ASSESSMENT:**	**MEDS PO:** / **MEDS IV:**	Discharge Plan of Care/Expected date of discharge/MD plan of care:	
Intake/Output: Last BM:		**P**roblems with Medications (>10): VACCINES: PNEUMOCOCCAL ☐ FLU ☐ ACCU-CHECK:	**P**oor Health Literacy/Teaching: Language Barrier ☐ Smoking ☐ Stroke ☐ Flap/Drain ☐ Other Nursing Plan of Care: Initiated ☐ Updated ☐ New ☐	

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