BRONXcare™
BRONX-LEBANON HOSPITAL CENTER

HAND-OFF FORM

Form To Be Completed By Referring Provider

Date of Request _____ _____

Med. Rec. Number _____ Authorization # (If applicable): _____

Referring Provider (Please Print) _____

Telephone _____ Pager Number _____

Location _____ Fax Number _____

Situation:

(Please be specific): _____

_____

_____

_____

Background

(Relevant History): _____

_____

_____

_____

Assessment

(Pertinent Physical Finding): _____

_____

_____

Current Vital Signs

BP _____ Pulse _____ List of Medications _____

Resp Rate _____ Allergies _____ _____

Temp _____ _____

Pertinent Studies (e.g, Radiology, Labs, etc) _____

_____

Recommendation: _____

_____

_____

Advanced Directives Status (Circle one, if appropriate): DNR DONOT INTUBATE OTHER: _____

Transfer Discussed With: _____

Transfer to (Circle one) EMERGENCY ROOM DIRECT ADMISSION BED# _____