The Children's Hospital *of* Philadelphia®

LAST NAME _____ FIRST NAME _____

MR# _____ DOB _____

PLACE PATIENT LABEL HERE *OR* COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

# RADIOLOGY NURSING PATIENT HAND OFF TEMPLATE

Room: _____ Weight: _____ Allergies: _____

Study/Procedure: _____

Indication: _____

☐ ID Band Check ☐ IV check ☐ Environmental Check (ie. stretcher in lowest position, suction, airway, etc)

**INPATIENTS:** ☐ N/A

Unit: _____ Nurse: _____ Ascom: _____

Precautions: ☐ Contact ☐ Droplet ☐ N/A

Medication/Infusion Instructions: _____

**REVIEW OF SYSTEMS (note exceptions):**

Neuro: _____ Respiratory: _____

Cardiac: _____ Musculoskeletal: _____

Gastrointestinal: _____ Genitourinary: _____

Integumentary: _____

Significant Past Medical History: _____

**SPECIAL CLEARANCE/PLANS?** (e.g., endocrine, cardiac) _____

Sedation Plan: ☐ Sedation ☐ General Anesthesia ☐ N/A

Sedation/GA consent? ☐ Y ☐ N ☐ N/A Procedure Consent: ☐ Y ☐ N ☐ N/A

Screening: ☐ Metal ☐ Contrast ☐ N/A Sedation Checklist: ☐ Y ☐ N ☐ N/A

Vascular Access: ☐ Central Line _____ ☐ PIV _____ ☐ Port _____

Labs to be drawn: _____ ☐ N/A

Pre-meds/Fluids: ☐ PO Versed ☐ Intranasal Versed ☐ EMLA ☐ Bolus

Accompanied by: ☐ Mother ☐ Father ☐ Other: _____

Interpreter Services Required: ☐ Yes ☐ No ☐ N/A

**POST-SEDATION:**

Complications: _____

**Med Totals:** Versed: _____ Last Dose @ _____

Fentanyl: _____ Last Dose @ _____

Pentobarb: _____ Last Dose @ _____

Ketamine: _____

**Adjuncts:** Glyco: _____

Zofran: _____

Other: _____

**Reversal Doses:** Narcan: _____ Flumazenil: _____ Succinylcholine: _____

**Recovery Start Time:** _____ **Oxygen/Airway Needs:** _____

**Fluids:** Bolus Complete/Total: _____ Maintenance Start/Rate: _____