Ticket to Ride

Date: _____ Time: _____

Going to: ☐ PT ☐ OT ☐ Clinic ☐ X-Ray ☐ ER
☐ OR ☐ Lab ☐ Hospital ☐ Other _____

S**ituation**	B**ackground**	A**ssessment**	R**ecommend**
Patient/Resident Name: _____ Date of Birth: _____ Allergies: _____ Current Location: ☐ ER ☐ LTC ☐ Hosp ☐ Clinic ☐ Other _____ Diagnosis: _____ Transportation Mode: ☐ Stretcher ☐ Wheelchair ☐ Bed ☐ Other: _____ Procedure: _____ _____ Procedure verified by RN *(initials)*: _____	☐ Isolation ☐ Chronic Dementia ☐ Blind ☐ Deaf ☐ Impaired Speech ☐ Bariatric ☐ Language ☐ Needs Interpreter ☐ No Code	**Patient/Resident:** ☐ Confused ☐ Oxygen: _____ liters ☐ IV ☐ Foley Catheter ☐ Other devices: _____ _____ ☐ Recent pain meds: _____ **Safety:** ☐ Falls risk ☐ Elopement risk ☐ Has chair alarm ☐ Has restraints ☐ Suicide precautions ☐ Close observation	**For procedure, patient can:** ☐ Walk short distances ☐ Stand alone briefly ☐ One assist ☐ Two assist ☐ Pivot only ☐ Needs mechanical lift ☐ No wt bearing: ☐ Rt side ☐ Lt side ***For additional questions concerning this patient/resident please Vocera:*** _____***RN/LPN***

This document is <u>NOT</u> part of the permanent medical record and does <u>NOT</u> replace verbal communication when indicated.

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TICKET TO RETURN

Date: _____ Time: _____

Returning to: ☐ LTC ☐ Hosp ☐ ER ☐ Clinic ☐ Other _____

Situation	Background	Assessment	Recommend
Patient/Resident Name: _____ Current Location: ☐ Lab ☐ X-ray ☐ Clinic ☐ ER ☐ PT ☐ OT ☐ Other _____ Transportation Mode: ☐ Stretcher ☐ Wheelchair ☐ Bed ☐ Other: _____	**Therapies, Tests & Procedures Completed** ☐ EKG ☐ X-ray ☐ CT ☐ MRI ☐ Lab Draw - Body location: _____ ☐ PT ☐ OT ☐ Other _____	**Patient/Resident:** ☐ Change in status *(incl. pain, SOB, etc.)*: _____ Current findings: _____ **Safety:** ☐ Oxygen connected ☐ IV infusing/plugged-in ☐ Foley patent ☐ Alarms engaged ☐ Restraints secure	☐ See new physician orders ☐ Other _____ ☐ ***Verbal report to:*** _____***RN/LPN upon return.*** _____ *Signature of Transporting Staff*

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TICKET TO RETURN

Date: _____ Time: _____

Returning to: ☐ LTC ☐ Hosp ☐ ER ☐ Clinic ☐ Other _____

Situation	Background	Assessment	Recommend
Patient/Resident Name: _____ Current Location: ☐ Lab ☐ X-ray ☐ Clinic ☐ ER ☐ PT ☐ OT ☐ Other _____ Transportation Mode: ☐ Stretcher ☐ Wheelchair ☐ Bed ☐ Other: _____	**Therapies, Tests & Procedures Completed** ☐ EKG ☐ X-ray ☐ CT ☐ MRI ☐ Lab Draw - Body location: _____ ☐ PT ☐ OT ☐ Other _____	**Patient/Resident:** ☐ Change in status *(incl. pain, SOB, etc.)*: _____ Current findings: _____ **Safety:** ☐ Oxygen connected ☐ IV infusing/plugged-in ☐ Foley patent ☐ Alarms engaged ☐ Restraints secure	☐ See new physician orders ☐ Other _____ ☐ ***Verbal report to:*** _____***RN/LPN upon return.*** _____ *Signature of Transporting Staff*

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