Ticket to Ride

Date: ______ Time: ______

Going to: ______

Situation	Background	Assessment	Recommend
Patient Name: ______ Date of Birth: ______ Allergies: ______ Current Location: ______ 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:** ○ Confused ○ Oxygen: ______ liters ○ IV ○ Foley Catheter ○ Other devices: ______ ______ ○ Recent pain meds: ______ ______ **Safety:** ○ Falls Risk ○ Elopement Risk ○ Has chair/bed alarm ○ Has restraints ○ Suicide Precautions ○ Close Observation ○ Forensic Patient	**For procedure, patient can**: ○ Walk short distances ○ Stand-alone briefly ○ One assist ○ Two assist ○ Pivot only ○ Needs mechanical lift ○ No weight bearing: ○ Right side ○ Left side ***For additional questions concerning this patient please call:*** ______ ***RN/LPN*** ***Contact Tel #:*** ______

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

Ticket to Return

Date: ______ Time: ______

Returning to: ______

Situation	Background	Assessment	Recommend
Patient Name: ______ Current Location: ○ PT ○OT ○ Radiology ○OR ○ Lab ○ Other: ______ Transportation Mode: ○ Stretcher ○ Wheelchair ○ Bed ○ Other: ______	**Therapies, Tests & Procedures Completed** ○ EKG ○ Echo ○ X-ray ○ CT ○ MRI ○ Ultrasound ○ Lab Draw-Body Location: ______ ○ PT ○ OT ○ Other______ ______ ______	**Patient:** ○ Change in status (include pain, SOB, AMS, 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.*** Completed by: ______ (Signature)

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