HNHB LHIN COMPLEX CARE CLINICAL UPDATE TOOL	Patient Label or Bradma
Date (yyyy/mm/dd):	
Sending Organization:	
Receiving Organization:	
Receiving Organization Contact Name and Number:	

Vital Signs:	BP	Pulse	Resp	Temp	Height	Current Weight	
Allergies:	Yes	No	List attached: Yes				
Isolation Precautions:	Yes	No	MRSA	VRE	ESBL	Cdiff	Other
Is patient from an Outbreak Area:	Yes	No					
Last Swab Date:							
Code Status:							
Outstanding Appointments, Consultation & Referrals:							
Relevant Lab (BS, INR, etc.) & Diagnostic Test Results:	Yes	No	Please Attach: Yes				
Outstanding Lab & Diagnostic Tests:							

Invasive Device	Tracheostomy Tube	Feeding Tube, ie PEG	Urinary Catheter	CVAD
Date Inserted:				
Inserted by:				
Date Changed:				
Type: Size:			Foley / Suprapubic	
Oxygen:	Yes / No	Oxygen %	Nasal Prongs	Mask
Colostomy:	Yes / No	Ileostomy: Yes / No	Other:	
Special Diet:	Yes / No	Type:		
Patient Receiving Enteral Feeding:	Yes	No		
Type of Formula:		Amount and Rate:		
Behaviours: Exit Seeking:	Yes	No	Describe:	
Behaviours: Physically Aggressive/Verbally Aggressive/Noncompliant:	Yes	No	Describe:	
Mobility Aids (List All):				
Patient's Current Method of Transfer:				

FALLS: Patient is at Risk for Falls:	Yes	No				
Patient has had a Fall:	Yes	No	Date of Last Fall:			
Risk Factors Identified:	Yes	Copy of the Organization's Risk Assessment: or List Attached:				
Frequency of Falls:						
Severity of Falls:						
Contributing Factors for Falls:						
Restraints in Use:	Yes	No	Bed:	Type:	Chair:	Type:
Plan for Least Restraint:						
Equipment: Type of Bed Recommended (i.e. high-low bed):						
Devices Recommended (i.e. bed exit alarm, transfer device):						

Interventions:	Exercise	Medications	Hip Protectors	Vitamin D	Education
Interventions:	Environmental Modifications:				

HNHB LHIN COMPLEX CARE CLINICAL UPATE TOOL

PRESSURE ULCERS:	Yes	No	Is at Risk for Pressure Ulcers	Yes	No
Risk Factors:					
Current Braden Scale Score:					
Stage, Site and Size of Existing Ulcer(s)					
Odour	Sinus Tracts	Undermining	Tunneling	Exudate	
Appearance of Wound Bed:					
Condition of Surrounding Skin (periwound) and Wound Edges:					
History of Ulcers:					
Previous Treatments and Products Used:					
Type of Bed/Mattress and/or Seating Recommended:					
Type of Dressing Currently Used and Frequency of Change:					
Contact Name (i.e. Skin/Wound Clinician, Charge Nurse):					

Has Patient Received 2 Step TB Test:	Yes	No	Date:	Results:
Has Patient Received the Influenza Vaccine:	Yes	No	Date:	
Has Patient had Pneumovax	Yes	No	Date:	

CURRENT STATUS	**Indep**	**Supv**	**Min Ax1**	**Mod Ax2**	**Lift or Depend**
Bathing					
Dressing					
Feeding					
Stairs					
W/C Mobility					
Bladder Continence					
Bowel Continence					
I-ADL					

Patient Goals and Discharge Plan:

Person Completing Form and Contact Number:

Medication List Attached Including Last Dose(s) Given	**Yes**