**CHUGG-OUT (SICU to OU/Floor Transfer)**

***SICU MD HANDOFF***

*Note - The MD Handoff should be up to date, including all required elements in the .SICUHANDOFF template. Required elements include date of admission, one-liner, past medical history, injury list, and list of other major ICU problems. For each problem, name consulted services (with date of sign-off if no longer following), summary of treatments received, and ongoing treatment plan.*

\*\*\*

***MD Consults:***

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  ACCS | [ ]  Cardiology | [ ]  Endo | [ ]  ENT |
| [ ]  GI | [ ]  Hand | [ ]  ID | [ ]  Neuro |
| [ ]  NSGY | [ ]  Ortho | [ ]  Pain  | [ ]  PRS |
| [ ]  Renal | [ ]  Spine-NSGY | [ ]  Spine-Ortho | [ ]  Urology |

[ ]  Other:

***Rehab/Ancillary Consults:***

|  |  |
| --- | --- |
| [ ]  BI (trauma patient with LOC) | [ ]  Chemical dependency |
| [ ]  PT [ ]  OT [ ]  Speech | [ ]  PM&R |
| [ ]  SMART (stroke patient) | [ ]  Wound care |

***SITUATIONAL AWARENESS***

PERTINENT physical exam findings on day of transfer: \*\*\*

***New findings that warrant follow-up and pending studies:***

[ ]  Yes--describe:

[ ]  None

***Important changes to home medications:***

[ ]  Home medications stopped/on hold:

[ ]  Dose changes:

[ ]  No notable changes

***New medications to consider stopping prior to hospital discharge:***

[ ]  New antipsychotic (started for ICU delirium):

[ ]  Other:

***Disposition/Planning:***

Eval by LTAC/Rehab/SNF

[ ]  Yes [ ]  No [ ]  N/A

 Facility:

***Best Family Contact:***

***CURRENT ANTICOAGULANT THERAPY***

[ ]  VTE Prophylaxis

 [ ]  Heparin [ ]  Lovenox [ ]  SCDs

[ ]  IVC Filter [ ]  Other:

 [ ]  None – Reason:

[ ]  Therapeutic Anticoagulation

 *Indication:*

[ ]  Heparin [ ]  Lovenox [ ]  Other:

Any previous issues with tolerating anticoagulants?

 [ ]  Yes [ ]  No

 *Describe:*

Venous duplex performed?

 [ ]  Yes ---> *Most recent findings:*

[ ]  No

***CURRENT ANTIMICROBIAL THERAPY***

*Note - Planned duration may be a number of days or a criterion such as "while drain in place" or "until blood cultures negative"*

[ ]  N/A - No current antimicrobial therapy

* **[Antibiotic/Antimicrobial\_Name]***Indication:*
*Start Date:*
*Planned Duration:*
* **[Antibiotic/Antimicrobial\_Name]***Indication:*
*Start Date:*
*Planned Duration:*

*To insert additional antimicrobials, use the .SICUabx smart phrase.*

***LINES/DRAINS/AIRWAYS PRESENT***

@LDA(4,5,7,10,11,12,13,14,15,18,19,20,21,22,26,27,29,30,31,32,33,34,35,36,37:0:1,1:2)@

***TO-DO LIST PRIOR TO TRANSFER***

Make sure the following monitors or precautions are ordered if indicated:

Telemetry [ ]  Yes [ ]  No

Continuous pulse oximetry [ ]  Yes [ ]  No

OSA precautions [ ]  Yes [ ]  No

Difficult airway[ ]  Yes [ ]  No

Trach orders/signage[ ]  Yes [ ]  No

 Size/Type:

 Date placed:

Did patient require insulin while in SICU?

 [ ]  Yes, scheduled insulin

 [ ]  Yes, sliding scale only ----> d/c SICU insulin and order floor sliding scale insulin

 [ ]  No ----> d/c SICU insulin and blood glucose checks

Is the patient receiving TPN?

 [ ]  Yes ----> [ ]  Today's bag is ordered

 [ ]  No

Central line necessary? [ ]  Yes [ ]  No [ ]  N/A

Groin line necessary? [ ]  Yes [ ]  No [ ]  N/A

[ ]  Discontinue K/Mg/Phos repletion order (if applicable)

[ ]  Discontinue stress ulcer prophylaxis if no longer indicated

[ ]  "Signed & Held" orders reconciled (all orders either released or discontinued)

[ ]  **Sign-out was called to \*\*\* of the \*\*\* service.**

***QUESTIONS? Call \*\*\****