Bedside Shift Report

PATIENT INFORMATION

Name: _____ Age: _____

Diagnosis: _____ Room number: _____

Code status: _____ Emergency contact: _____

GENERAL CONDITION

General condition

Vital signs

Level of consciousness: _____ Pain level: _____

MOBILITY STATUS

Mobility status: _____ Activity level: _____

SKIN INTEGRITY

Skin integrity

Skin assessment

PREVENTATIVE MEASURES

Preventative measures

NUTRITION AND HYDRATION

Diet information

Hydration details

MEDICATIONS

Medication name: _____ Dosage: _____

Frequency: _____

Notes

Pain management

PROCEDURES/TESTS

Recent tests

Schedules procedures

SPECIAL EQUIPMENT/ASSISTANCE

Equipment in use

Assistance needed

FAMILY AND SOCIAL SUPPORT

Family visits

Support system

PLAN OF CARE

Plan of care

Concerns

Plan

Summary

Additional notes

Name of healthcare provider – signature

Date: _____ dd / mm / yyyy