Ticket to Ride

Time: _____ Date: _____ Going to: _____

Situation	Background	Assessment	Recommend
Patient Name: _____	o Isolation	**Patient:**	**For Procedure, patient can:**
		o Confused	o Walk short distances
Date of Birth: _____	o Chronic Dementia	o Oxygen: ___ liters	o Stand-alone briefly
		o IV	o One assist
Allergies: _____	o Blind	o Foley Catheter	o Two assist
		o Other devices: _____	o Pivot only
Current Location: _____	o Deaf	_____	o Needs mechanical lift
			o No weight bearing:
Diagnosis: _____	o Impaired Speech	o Recent pain meds: _____	o Right side
		_____	o Left side
Transportation Mode:	o Bariatric		
o Stretcher o Wheelchair o Bed		**Safety:**	***For additional questions concerning this patient please call***
o Other: _____	o Language	o Falls Risk	
		o Elopement Risk	
	o Needs Interpreter	o Has chair/bed alarm	_____ RN/LPN
Procedure: _____		o Has restraints	
	o No Code	o Suicide Precautions	***Contact Tel #:_____***
Procedure verified by RN (initials): _____		o Close Observation	
		o Transmission-Based Precaution	

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

Ticket to Return

Time: _____ Date: _____ Returning to: _____

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

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