Trillium Health Partners

mississauga halton /central west regional cancer program
in partnership with cancer care ontario

Carlo Fidani Regional Cancer Centre Patient Hand Over Tool (CFRCC)

The purpose of the document is to facilitate communication of patient information to safely care for the patient during their visit.

This document must be completed by the sending facility for each visit and sent with the patient's chart

Patient Name: _____ **ID#:** _____ **DOB:** _____

Sending Facility: _____ **Contact #:** _____ **(if more information is required)**

Date of appointment: _____

Information to be sent with patient

- ❒ Chart & Medication Administration Record (MAR)
- ❒ OHIP Card, red & white OHIP cards also require additional photo ID
- ❒ CD Rom of all diagnostic imaging as requested for new patient consult visits
- ❒ Do not resuscitate (DNR)/No Cardio-pulmonary resuscitation (No CPR) documentation if applicable
- ❒ All required medications including PRN

Isolation ❒ No ❒ Yes must inform ahead of time by phone
Radiation Therapy- 905-813 4411 / Clinic - 905 813 4471
Type_____

Code status ❒ No CPR / DNR ❒ Full Code

Vital signs HR_____ BP_____ Temp_____ Resp_____

Allergies ❒ No ❒ Yes_____

Oxygen ❒ No ❒ Yes O^2 Flow Rate_____

Ambulatory ❒ Self ❒ Assist device ❒ 1 assist ❒ 2 assist

Diabetic: ❒ No ❒ Yes (if yes, please supply food)
Time of last meal_____ Insulin last given at_____

Pain scale ___ /10 ❒ Last Analgesic Given: Time_____ Type_____

Pacemaker ❒ No ❒ Yes (if yes please send details of make & model)

Sending staff Name and designation_____ Date_____ Time_____

*****This is an outpatient facility and care of the patient remains the responsibility of the sending facility for the duration of their visit.*****