

**APPENDIX E  
CAREGIVER HANDOFF SHEET**

Use this sheet when another person is taking over care temporarily.

**Patient Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Primary Caregiver:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Temporary Caregiver:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Duration of Care: From** \_\_\_\_\_ **to** \_\_\_\_\_

**Shift Schedule: From:** \_\_\_\_\_ **Till:** \_\_\_\_\_ **Overnight:** \_\_\_\_\_

**CURRENT STATUS:**

**Baseline Mental Status:** Alert Oriented Coherent Confused Belligerent

**Overall condition today:** Stable Good day Not feeling well Cooperative

Uncooperative

**Mood:** Pleasant Anxious Agitated Tired Other: \_\_\_\_\_

**Pain level (0-10):** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Recent changes or concerns:** \_\_\_\_\_

**What to monitor closely:** \_\_\_\_\_

**MEDICATIONS DUE DURING YOUR SHIFT:**

**Medication:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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(See full medication list in binder for details)

### MEALS AND SNACKS

**Meal/snack time:** \_\_\_\_\_

**What to offer:** \_\_\_\_\_

**Meal/snack time:** \_\_\_\_\_

**What to offer:** \_\_\_\_\_

**Notes (any preferences, dietary restrictions):** \_\_\_\_\_

**FLUIDS: Encourage fluids:**  **Yes Goal:** \_\_\_\_\_ **cups**

**Any restrictions:** \_\_\_\_\_

**Why?** \_\_\_\_\_

**PERSONAL CARE NEEDED:**  **Assistance with toileting (frequency):**

**Assistance with dressing**  **Wound care or skin care (instructions:**  **Other:**

**ACTIVITY:**

**Usual activities:** \_\_\_\_\_

**Mobility:**  **Independent**  **Uses walker/cane**  **Needs assistance** **Fall risk:**

**Low**  **Moderate**  **High (stay nearby)**

**SAFETY NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Follow the Laws of Protected Health Information (PHI)

45 CFR 160.103

"Protected health information means individually identifiable health information transmitted or maintained in any form or medium."



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**EMERGENCY CONTACTS:**

**Primary Caregiver:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Backup Contact Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Primary Doctor:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**CALL PRIMARY CAREGIVER IF:**

- Any concerning symptoms (see Red Flags list)
- Fall or injury
- Refusal to eat or take medications
- Confusion or change in mental status
- Any questions or concerns

**CALL 911 IF:**

- Difficulty breathing
- Chest pain
- Stroke symptoms (FAST)
- Loss of consciousness
- Severe injury

**NOTES FROM THE SHIFT (to be filled out by temporary caregiver):**

**Medications given:** \_\_\_\_\_

**Meals eaten:** \_\_\_\_\_

**Fluids consumed:** \_\_\_\_\_

**Activity:** \_\_\_\_\_

**Mood/behavior:** \_\_\_\_\_

**Any issues or concerns:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Temporary Caregiver Signature:** \_\_\_\_\_

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