

**PATIENT MOVEMENT RECORD**

**PCA / PNB / EPIDURAL HAND-OFF**

DATA PROTECTED BY PRIVACY ACT OF 1974

PERMANENT MEDICAL RECORD

ASSESSMENT / PROGRESS (Continued)

NAME (Last, First, Middle Initial)	DOB	STATUS	SERVICE	CITE # / PATIENT ID #
------------------------------------	-----	--------	---------	-----------------------

ALLERGIES (Food, Drug, and Latex)

DATE	TIME (Zulu)	NOTES
		<b>INITIAL PHYSICIAN ORDER VERIFICATION AND PUMP SET-UP</b>
		Privileged Provider Order for PCA / PNB / Epidural pump verified: / (RN #1 & #2 initials)
		Break through pain order verified / (RN #1 & #2 initials)
		Over sedation treatment medication order verified: / (RN #1 & #2 initials)
		Medication: (Circle One)
		(1) Morphine 1 mg / ml
		(2) Hydromorphone (Dilaudid) 0.2 mg / ml
		(3) Alternate Medication: Concentration:
		Order: (1) Program #: (2) Basal Flow Rate: (3) Bolus Dose:
		(4) Lock Out Dose/Time: / (5) Volume to be infused:
		Pump Locked: Y / N / (RN #1 & #2 Initials)
		Verify Correct Tubing Connections: / (RN #1 & #2 Initials)
		Pump Tubing Labeled: Y / N Patient Teaching: Y / N / (RN #1 & #2 Initials)
		<b>RN#1 SIGNATURE &amp; INITIALS:</b>
		<b>RN#2 SIGNATURE &amp; INITIALS:</b>
		***** PATIENT CARE HAND-OFF #1 *****
		Privileged Provider Order Verified: Y / N Program Verified Per Order: Y / N / (RN #1 & #2 Initials)
		Pump Locked: Y / N / (RN #1 & #2 Initials)
		Verify Correct Tubing Connections: / (RN #1 & #2 Initials)
		Infusion History:
		(1) Total Volume In fused: (2) # of Boluses Delivered:
		(3) # of Bolus Attempts: (4) Elapsed Time:
		(5) History Cleared At this Time: Y / N (6) IV Site Assessed: Y / N
		(7) Pump Tubing Labeled: Y / N (8) Patient Teaching: Y / N / (RN #1 & #2 Initials)
		<b>RN#1 (Sending) SIGNATURE &amp; INITIALS:</b>
		<b>RN#2 (Receiving) SIGNATURE &amp; INITIALS:</b>

Controlled Drug Accountability \_\_\_\_\_ MANDATORY

\*\*\*\*\* EnRoute Care Documentation Reference: AFI41-307, Atch 16 \*\*\*\*\*

NOTE: While on a **PCA**, assess and document is at a minimum of q2 hr: baseline pain score, vital signs with pulse oximetry, MAAS score, and medication side effects. **Epidural infusion** assessment and documentation will include dermatome levels. **Peripheral nerve Block (PNB)** assessment and documentation will include sensation and circulation distal to the catheter insertion site.

Continue flow sheet on the back of this form.

**PATIENT MOVEMENT RECORD**

**PCA/PNB/EPIDURAL HAND-OFF**

DATA PROTECTED BY PRIVACY ACT OF 1974

PERMANENT MEDICAL RECORD

ASSESSMENT/PROGRESS (Continued)

NAME (Last, First, Middle Initial)	DOB	STATUS	SERVICE	CITE # / PATIENT ID#
------------------------------------	-----	--------	---------	----------------------

Allergies (Food, Drugs, and Latex)

DATE	TIME (Zulu)	*****PATIENT CARE HAND-OFF#2*****
		Privileged Provider Order Verified: Y/N      Program Verified Per Order: Y/N      /      (RN #1&#2Initials)
		Pump Locked: Y/N      /      (RN#1&#2 Initials)
		Verify Correct Tubing Connections:      /      (RN#1&#2Initials)
		Infusion History:
		(1) Total Volume In fused:      (2) # of Boluses Delivered:
		(3) # of Bolus Attempts:      (4) Elapsed Time:
		(5) History Cleared At this Time: Y/N      (6) IV Site Assessed: Y/N
		(7) Pump Tubing Labeled: Y/N      (8) Patient Teaching: Y/N      /      (RN#1&#2Initials)
		<b>RN#1 (Sending) SIGNATURE &amp; INITIALS:</b>
		<b>RN#2 (Receiving) SIGNATURE &amp; INITIALS:</b>
		*****PATIENT CARE HAND-OFF#3*****
		Privileged Provider Order Verified: Y/N      Program Verified Per Order: Y/N      /      (RN #1&#2Initials)
		Pump Locked: Y/N      /      (RN#1&#2 Initials)
		Verify Correct Tubing Connections:      /      (RN#1&#2Initials)
		Infusion History:
		(1) Total Volume In fused:      (2) # of Boluses Delivered:
		(3) # of Bolus Attempts:      (4) Elapsed Time:
		(5) History Cleared At this Time: Y/N      (6) IV Site Assessed: Y/N
		(7) Pump Tubing Labeled: Y/N      (8) Patient Teaching: Y/N      /      (RN#1&#2Initials)
		<b>RN#1 (Sending) SIGNATURE &amp; INITIALS:</b>
		<b>RN#2 (Receiving) SIGNATURE &amp; INITIALS:</b>
		*****PATIENT CARE HAND-OFF#4*****
		Privileged Provider Order Verified: Y/N      Program Verified Per Order: Y/N      /      (RN #1&#2Initials)
		Pump Locked: Y/N      /      (RN#1&#2 Initials)
		Verify Correct Tubing Connections:      /      (RN#1&#2Initials)
		Infusion History:
		(1) Total Volume In fused:      (2) # of Boluses Delivered:
		(3) # of Bolus Attempts:      (4) Elapsed Time:
		(5) History Cleared At this Time: Y/N      (6) IV Site Assessed: Y/N
		(7) Pump Tubing Labeled: Y/N      (8) Patient Teaching: Y/N      /      (RN#1&#2Initials)
		<b>RN#1 (Sending) SIGNATURE &amp; INITIALS:</b>
		<b>RN#2 (Receiving) SIGNATURE &amp; INITIALS:</b>