Nursing Handover Tool

(Systemic Therapy, Radiation and Brachytherapy, Dual Modality)

Patient Identification

S Situation

Diagnosis:

MRP:

Appointment Date:

Appointment Location:

Purpose of Appointment/Admission:

Relevant Medical History:

Allergies:

Isolation Requirement:

Falls Risk: ☐No ☐ Yes **Violence Risk:** ☐No ☐ Yes

Goals of Care (GOC):

Accompanied by:

Mobility:

B Background

Treatment Intent: ☐ Curative ☐ Palliative ☐ Unknown ☐ Not on Active Treatment

Systemic Therapy: ☐No ☐ Yes ☐ Not Applicable

Chemotherapy: ☐No ☐ Yes

Hormonal Therapy: ☐No ☐ Yes

Immunotherapy: ☐No ☐ Yes

Bispecific Antibody: ☐No ☐ Yes

Other:

Copy of Protocol Included: ☐No ☐ Yes

Protocol Code:

Cycle + Day:

☐ **48 Hour Hazardous Drug Precautions Until:**

Systemic Therapy Medications Administered:

Unexpected Events During Treatment:

Radiation Therapy: ☐No ☐ Yes ☐ Not Applicable

External Beam Radiation ☐ No ☐ Yes

Sites(s):

Patient Received a Radiopharmaceutical (e.g., Pluvicto):

☐ No ☐ Yes

Radiation Side Effects:

Brachytherapy ☐ No ☐ Yes

Radiation Precautions:

☐ Pluvicto

☐ Low Dose Radiation – See Radiation Safety for Brachytherapy Seed Implant (LDR) Patients

Date/Time of Last Radiation Dose:

Next Dose Radiation Due:

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	Supportive Care:				
	Medications administered: **Hydration administered:**				
A **Assessment**	**Time of Most Recent Vitals:**				
	Temp:	**HR:**	**RR:**	**SPO2:**	**BP:**
	Venous Access Device (VAD):	**External length:**	**Location:**	**Inserted (date):**	
	Date of Last VAD Dressing Change:		**Date of Last Flush:**		
	Treatment Related Side Effects: (i.e immune mediated adverse events):		**Bispecific Antibody:** CRS assessment: ☐ attached ☐ N/A ICE assessment: ☐ attached ☐ N/A		
	Interventions and Medications (Including completed or pending investigations & consults):				
R **Recommen-dation**	**Priority Patient Care Needs:**				
	Future Scheduled Oncology Supportive Care Meds (i.e., antiemetics, steroids, etc.) : ☐No ☐ Yes		**Oncology Meds Dispensed:** ☐No ☐ Yes **Future Cancer Treatment Medication doses:** ☐No ☐ Yes		
	Med:_____ **Time/Date:**_____		**Med:**_____ **Time/Date:**_____		
	Med:_____ **Time/Date:**_____		**Med:**_____ **Time/Date:**_____		
	Med:_____ **Time/Date:**_____		**Med:**_____ **Time/Date:**_____		
Completed by (name and designation): **Contact Number:**				**Date:**	