Patient Handoff Report

I – Identification
(Patient's name, age, gender, and date of birth)
M – Mechanism/Medical Complaint
(What happened? Nature of the illness or mechanism of injury)
I –Injuries/Information Related to the Complaint
(Description of injuries or relevant medical history and findings.)
S – Signs
(Vital signs (HR, BP, RR, Temp, SpO_2, GCS, BGL. Include any abnormal or deteriorating trends.)
T – Treatment and Trend
(What has been done so far - interventions, medications, oxygen, IV access, etc., and patient response to treatment.)
A – Allergies
(Known drug, food, or environmental allergies.)
M – Medications
(Any regular medications the patient takes, including recently administered ones.)
B – Background
(Relevant medical history (chronic conditions, surgeries, mental health, etc.)
O – Other Information
(Social situation, time of symptom onset, DNAR/Advance Directive, accompanying family, valuables, or anything not previously mentioned.)