SOP: Pre-transport Patient Assessment and Documentation

This SOP details the **pre-transport patient assessment and documentation** process, emphasizing thorough evaluation of patient condition, vital sign monitoring, identification of potential risks, and accurate recording of all findings. Its goal is to ensure safe and effective patient transfer by providing healthcare professionals with clear guidelines for assessment, communication, and documentation prior to transportation.

1. Purpose

To ensure that all patients are thoroughly assessed, risks are identified and mitigated, and all findings are accurately documented before transport to guarantee patient safety and continuity of care.

2. Scope

This SOP applies to all healthcare personnel involved in preparing patients for any type of transfer, including intra-hospital and inter-hospital transport.

3. Responsibilities

- **Registered Nurses/Medical Staff:** Conduct assessments, record findings, and communicate with transport teams.
- **Documentation Staff:** Ensure all forms are completed and records are up to date.
- **Transport Team:** Review assessment, confirm understanding of any special requirements.

4. Procedure

1. **Review Patient Information:**
    - Identify patient using two identifiers (name, DOB/MRN).
    - Review medical records for diagnosis, current condition, relevant history, allergies, DNR status, and ongoing treatments.
2. **Conduct Physical Assessment:**
    - Obtain and record baseline vital signs: temperature, pulse, respiration, blood pressure, SpO_2.
    - Assess airway, breathing, circulation, neurological status, and pain.
    - Evaluate IV lines, drains, wounds, and catheters for security and function.
3. **Identify Potential Risks:**
    - Document mobility status and fall risk.
    - Identify infection control issues (e.g., isolation requirements).
    - Note any specific transport risks (e.g., need for ventilator, risk of deterioration).
4. **Confirm Transport Requirements:**
    - Oxygen, monitoring equipment, medications, escorts, and special instructions.
5. **Documentation:**
    - Complete pre-transport checklist and assessment form.
    - Record time, date, and name/signature of assessor.
    - Notify and communicate findings to receiving/transport team and document handover.
6. **Reassess Immediately Prior to Transport:**
    - Repeat vital signs if significant time has elapsed.
    - Update documentation with changes.

5. Documentation Template

Item	Details/Findings
Patient Name & MRN	
Date/Time	
Vital Signs (T/P/R/BP/SpO_2)	
Primary Diagnosis	
Current Condition & Treatments	

IV Lines/Drains/Catheters	
Allergies/DNR Status	
Mobility & Fall Risk	
Infection Control Needs	
Special Equipment/Needs	
Assessment Completed By	
Handed Over To	

6. References

- Hospital Policy on Patient Transport
- Best Practice Guidelines for Safe Patient Transfers

7. Revision History

Date	Revision	Author