FORM NO. 10

UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

NAME OF HEALTH FACILITY

……..

NURSING SHIFT HANDING OVER REPORT FORM

Date ……..…… Time…… Department…….…….. Ward…….…….. Shift (Night, Morning, Evening, Day)……..

Description of serious patient										**Items handled**
Bed. No.	**DOA**	**Name**	**Reg. No.**	**Age**	**Sex**	**Diagnosis**	**GCS**	**Nursing Care Given**	**Pending Care Issues**	Eg., Thermometer, Dangerous drugs, emergency drugs etc.

Summary for Ward status per shift (to be filled by shift Incharge)

Number of previous patients	**Admission**	**Discharge**	**Transfer**		**Referral**		**Absconded**	**DAMA**	**No. of present patients**	**Total Deliveries**	**Pre-op Patients**	**Surgeries**		**Post-op patients**	**Death**	**Total staff**	
			IN	**OUT**	**Received**	**Out**						**Major**	**Minor**			**Nurses**	**H/Ass**

Any other event/incidence to report……..

……

Reported by……Signature…… Received by…… Signature……