**Tips for Communicating Assessment Findings**

The timely reporting of abnormalities and changes in status is essential. It must be remembered that a resident's medical provider may not recall the details about the resident's condition and care, therefore, providing a concise summary can enable the provider to remember important facts and have a basis of comparison for what currently is being reported. When communicating assessment findings it is beneficial to include:

* Background information as needed (e.g., age, date of admission, major diagnoses, any recent incidents)
* Medications prescribed
* General physical and mental status
* Intake and output
* Current vital signs and how they may differ from usual ones
* Examination findings
* Signs and symptoms that may be present (Describe how long they have been present, what triggers them, and how they are relieved.)
* Results of recent lab tests
* Any recent incidents