

**PATIENT BELONGINGS INVENTORY**

ARTICLES OF CLOTHING BROUGHT TO HOSPITAL					
Bathrobe	Dress	Jeans/pants	Slippers/Socks	Sweater	
Belt	Nightgown	Shirt	Shoes/Boots	Sweatpants	
Bra	Hat	Pajamas	Skirt	Sweatshirt	
Coat/Gloves	Jacket	T-Shirt	Underwear	Other:	

Other: \_\_\_\_\_

VALUABLES BROUGHT TO HOSPITAL					
Hearing Aid ___ Right ___ Left	Walker/Cane	Dentures ___ Upper ___ Lower	Jewelry	Purse	
	Braces/Splints			Keys	Wallet
Cell Phone/ Charger	Prosthetics _____ _____	Medication <input type="checkbox"/> Sent Home <input type="checkbox"/> Pharmacy	Eye Wear ___ Glasses ___ Contacts	Money \$ _____. # of Credit Cards ____ <input type="checkbox"/> Sent Home <input type="checkbox"/> Cashier Envelope #: _____	
Lap Top					
Other:					

Other: \_\_\_\_\_

\*Denotes items secured on Unit

I have read the following and acknowledge:

- **McLaren Flint will not be liable (responsible) for any money or property of any kind retained by me or kept in my possession while I am at the hospital.**
- Please take all Valuables home when possible.
- **After 60 DAYS McLaren Flint will dispose of all unclaimed property left at the Medical Center.** Please call Security at (810) 342-3333, to claim any valuables after discharge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time: \_\_\_\_\_ am / pm  Patient  Responsible Party Relationship (to patient): \_\_\_\_\_

Sending Unit: \_\_\_\_\_ Receiving Unit: \_\_\_\_\_ Nursing Staff Signature: \_\_\_\_\_

Signature NOT Obtained Because: \_\_\_\_\_  DOA

Patient has no belongings or belongings sent home with Patient Family or Representative.

**PATIENT TRANSFER BELONGING INFORMATION**

<b>Clothing &amp; Valuables with Patient as Indicated Above</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>From room#:</b> _____ <b>To room #:</b> _____	Date: ____ Initials ____ Changes listed below: _____ _____ _____	<b>Clothing &amp; Valuables with Patient as Indicated Above</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>From room#:</b> _____ <b>To room #:</b> _____	Date: ____ Initials ____ Changes listed below: _____ _____ _____
<b>Clothing &amp; Valuables with Patient as Indicated Above</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>From room#:</b> _____ <b>To room #:</b> _____	Date: ____ Initials ____ Changes listed below: _____ _____ _____	<b>Clothing &amp; Valuables with Patient as Indicated Above</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>From room#:</b> _____ <b>To room #:</b> _____	Date: ____ Initials ____ Changes listed below: _____ _____ _____

**For use by Security only:**

Contraband/Weapon(s) (Guns, Knives and any Object similarly used): \_\_\_\_\_

Security Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Envelope #: \_\_\_\_\_

All of my belongings have been returned to me.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

