PATIENT CARE REFERRAL FORM

NURSING: Self Care Status Check Functional Level		Independent	Needs Assistance	Unable
Locomotion	Bed to Chair			
	Walking			
	Stairs			
	Wheelchair			
	Crutches			
	Walker			
	Cane			
Activities	Bathing			
	Dressing			
	Eating			
	Brushing teeth			
	Shaving			
	Toileting			
	Uses Commode			
	Uses bedpan/urinal			

Bowel & Bladder Program: ❍ No ❍ Yes
Incontinence: ❑ Bladder ❑ Bowel
Date of Last BM:_____
Catheter: Type _____
Date last changed: _____
Weight:_____ Height:_____ Date:_____
Anointed: ❍ No ❍ Yes Date:_____

Check if pertinent: (describe at right) ➔

DISABILITIES

❑ Amputation ❑ Other_____
❑ Paralysis
❑ Contractures

IMPAIRMENTS

❑ Speech ❑ Sensation
❑ Hearing ❑ Pressure Ulcer/Injury
❑ Vision ❑ Other_____

COMMUNICATION

❑ Can write ❑ Can read
❑ Talks ❑ Non-verbal
❑ Understands speaking ❑ Other Language
❑ Understands English ❑ Needs interpreter

BEHAVIOR

❑ Alert ❑ Withdrawn
❑ Forgetful ❑ Wanders
❑ Noisy ❑ Aggressive
❑ Confused ❑ Other_____

REQUIRES

Mark "S" if sent; "N" if needed

___Colostomy Care ___Dentures
___Cane ___Eye Glasses
___Crutches ___Hearing Aid
___Walker ___Prosthesis
___Wheelchair ___Side Rails
___Restraint ___Alarm
___Other_____

Name: _____
Record #: _____
Transfer to: _____

PATIENT CARE PLAN:
(Explain details of care, teaching, habits, preferences, and goals.)

Signature & Title

Date Phone Number

NUTRITION: (discuss food preferences, understanding of diet, teaching needs and goals) Diet enclosed: ❍ No ❍ Yes

Signature & Title Date Phone Number

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APPROVED BY THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH