TRANSFER AND REFERRAL RECORD

HOSPITAL AND NURSING FACILITY

Transferred From	Name of Facility	
	Address	Phone
Transferred To	Name of Facility	
	Address	Phone

Reason for Transfer	Date of Admission	Date of Discharge/Transfer

DOB	Sex ❍ Male ❍ Female	Marital Status ❍ Single ❍ Married ❍ Widowed ❍ Divorced	**ADVANCE DIRECTIVES** ❍ No ❍ Yes ❑ Attached

Medicare No.	Medicaid No.	Other Insurance

Diagnosis(es)/Procedures	Is Resident/Patient aware of diagnosis? ❍ No ❍ Yes
Attending Physician	Phone
Relative/Resident Representative	Relationship
Address	Phone ❍ Mobile ❍ Home

ALLERGIES ❑ NKA
❑ Drug_____ ❑ Food_____ ❑ Other_____

MEDICATIONS ❑ MAR attached	**TIME OF LAST DOSE**	**TREATMENTS** ❑ TAR attached	**TIME OF LAST TRMT**
	❍ AM ❍ PM		❍ AM ❍ PM
	❍ AM ❍ PM		❍ AM ❍ PM
	❍ AM ❍ PM		❍ AM ❍ PM
	❍ AM ❍ PM		❍ AM ❍ PM
	❍ AM ❍ PM		❍ AM ❍ PM

COVID-19 Vaccination is up-to-date ❍ No ❍ Yes	Influenza Vaccination Date:_____	Pneumococcal Vaccination Specify type:_____ Date:_____	Tetanus/DTaP Vaccination Date:_____	Herpes Zoster Vaccination Date:_____

Ambulatory ❍ No ❍ Yes Needs Assistance ❍ No ❍ Yes	Diet	Enteral Feeding ❍ No ❍ Yes Order_____

Elimination:
Continent of Bowel ❍ No ❍ Yes Continent of Bladder ❍ No ❍ Yes Indwelling Catheter ❍ No ❍ Yes Date of Last BM:_____

Infection present ❍ No ❍ Yes, specify:_____

REMARKS AND PERTINENT INFORMATION
Briefly describe resident/patient's condition at time of transfer.

The transferring facility will be responsible for the safe transfer and care of the resident/patient during transfer.

Vitals at time of transfer: Temp_____ Pulse_____ Resp_____ BP_____ AP_____ O_2 Sat_____

❍ Information provided verbally to receiving facility before transfer
❍ Information provided electronically to receiving facility before transfer
❍ Information not provided verbally to receiving facility before transfer

Completed By - Signature/Title:_____ Date:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed