INSTRUCTIONS: See reverse side of yellow sheet for Instructions For Completion.
WHITE COPY – To Receiving Facility **YELLOW COPY –** Retained By Originating Facility

PATIENT TRANSFER FORM

(INTER-AGENCY REFERRAL)

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX ❑ M ❑ F	3. HEALTH INSURANCE CLAIM NUMBER
4. PATIENT'S ADDRESS *(Street Number, City, State, Zip Code)*		5. DATE OF BIRTH		RELIGION

7. DATE OF THIS TRANSFER	8. FACILITY NAME AND ADDRESS TRANSFERRING TO	PHONE #
11. DATES OF QUALIFYING STAY FROM / THRU	12-A. FACILITY NAME AND ADDRESS TRANSFERRING FROM	PHONE #
EMPLOYMENT RELATED ❑ YES ❑ NO / MEDICAID ELIGIBLE ❑ YES ❑ NO	12-B. QUALIFYING AND OTHER PRIOR STAY INFORMATION *(Including Medical Record Numbers)*	

13. INSURING ORGANIZATION OR STATE AGENCY NAME AND ADDRESS	14. POLICY OR MEDICAID NO.

CLINIC APPOINTMENT DATE TIME	❑ ATTACH CLINIC APPOINTMENT CARD	DATE OF LAST PHYSICAL EXAMINATION

ATTENDING PHYSICIAN INFORMATION

1. NAME AND ADDRESS OF PHYSICIAN AT NEW FACILITY

2. FINAL DIAGNOSIS(ES): ❑ COPY ATTACHED

PRIMARY:

ALL OTHER CONDITIONS:

IS ❑ PATIENT ❑ FAMILY AWARE OF DIAGNOSIS? ❑ YES ❑ NO
ADVANCE DIRECTIVES: ❑ YES ❑ NO ❑ ATTACHED

3. SURGICAL PROCEDURE(S) AND DATE(S) ❑ NONE

4. PHYSICIAN ORDERS ON TRANSFER: ❑ ATTACHED

5. ESTIMATED MEDICALLY NECESSARY STAY:
_____ DAYS _____ WEEKS OR _____ MONTHS

6-A. DRUG ALLERGIES: ❑ NONE

6-B. FOOD ALLERGIES: ❑ NONE

7. DIETARY ORDERS:

8. PHYSICIAN'S SIGNATURE DATE

NURSING EVALUATION

9. SPEECH	❑ NORMAL	❑ IMPAIRED	❑ UNABLE TO SPEAK	
10. HEARING	❑ NORMAL	❑ IMPAIRED	❑ DEAF	❑ LT EAR ❑ RT EAR
11. SIGHT	❑ NORMAL	❑ IMPAIRED	❑ BLIND	❑ LT EYE ❑ RT EYE
12. MENTAL STATUS	❑ ALWAYS ALERT	❑ OCCASIONALLY CONFUSED - FREQ.: _____		❑ ALWAYS CONFUSED
13. EATING	❑ INDEP.	❑ HELP WITH FEEDING	❑ STAFF FEEDS	
14. DRESSING	❑ INDEP.	❑ HELP WITH DRESSING	❑ STAFF DRESSES	
17. BOWEL & BLADDER	❑ INDEP.	❑ HELP TO BATHROOM	❑ BEDPAN/URINAL/ COMMODE	❑ INCONT. ❑ CATHETER
16. BATHING	❑ INDEP.	❑ BATHING WITH HELP	❑ BED BATH WITH HELP	❑ BED BATH
17. AMBULATORY STATUS	❑ INDEP.	❑ WALKS WITH ASSISTANCE	❑ HELP FROM BED TO CHAIR	❑ BED/CHAIR BOUND

18. WOUND CARE: ❑ NONE

19. INFECTION PRESENT: ❑ NO ❑ YES, SPECIFY

20. APPLIANCES OR SUPPORTS: ❑ NONE

21. NURSING ASSESSMENT AND RECOMMENDATIONS:

SUMMARY ATTACHED: ❑ YES ❑ NO

22. INFLUENZA VACCINATION: DATE_____/_____/_____
PNEUMOCOCCAL VACCINATION (specify) _____
DATE_____/_____/_____
TETANUS/TETANUS-DIPHTHERIA VACCINATION: DATE_____/_____/_____
OTHER:_____ DATE_____/_____/_____

23. SIGNATURE/TITLE DATE

SOCIAL EVALUATION

24. NAME AND ADDRESS OF PERSON TO CONTACT:

RELATIONSHIP TO PATIENT

TELEPHONE NUMBER ❑ MOBILE ❑ HOME

25. PATIENT LIVES:
❑ ALONE ❑ WITH FAMILY ❑ WITH SPOUSE ❑ OTHER EXPLAIN:

26. PATIENT ATTITUDE TOWARDS TRANSFER:

27. SOCIAL/EMOTIONAL FACTORS
SUMMARY ATTACHED: ❑ YES ❑ NO

28. POST STAY PLANS:

29. SIGNATURE/TITLE DATE

INSTRUCTIONS FOR COMPLETION

1. Identify name and address of physician responsible for continuing management of care at receiving facility.

2. Record all final diagnosis(es) for this stay or attach copy of completed face sheet of patient chart. Include all conditions which relate to this patient's need for hospital and SNF care. Identify patient/family awareness of diagnosis(es). Note existence of Advance Directives.

3. Record all surgical procedures with dates performed during hospital stay.

4. Record physician orders necessary for continuity of patient care upon transfer and pending first visit by physician responsible at receiving facility. This must include all medications (dosage and frequency), specific instructions for special treatments, ambulation and other activity. Attach additional documentation as needed.

5. Estimate the length of medically necessary stay at receiving facility.

6. Record any drugs for which there has been evidence of allergies in the past. Identify any food allergies.

7. Provide dietary instructions, including any special needs related to desirable fluid intake requirements, diet order, restrictions, etc.

8. Signature and date of attending or other physician responsible for care during stay at this facility.

9-17. Describe patient abilities in activities of daily living by checking only one box in each category.

18. Record wound care and indicate frequency of treatment.

19. Identify any/all active infections at time of transfer.

20. Identify ambulation aids, prostheses, respiratory aids, special shoes, special eye glasses, dentures, etc.

21. Record nursing intervention(s) necessary for the following:

    a) assessment of symptoms and reactions, etc.

    b) supervision and/or teaching of special treatments, (e.g., tracheostomy care, colostomy care, use of oxygen, etc.)

    c) attainment of nursing objectives

    ATTACH ADDITIONAL PAGES AS NECESSARY.

22. Complete the vaccination information.

23. Signature and title of nurse completing transfer form and date completed in this field.

24. Identify person to be notified of patient's status, as necessary. Include relationship to patient and telephone number.

25. Record patient's living status.

26. Record patient attitude towards:

    a) Diagnosis(es)

    b) Stay at originating facility

    c) Transfer to receiving facility

27. Identify any social or emotional factors the receiving facility should be aware of. Note attachment of additional information.

28. Record whether patient will be discharged to family, self, another unit of same facility, another facility, or will need Home Health Agency Care.

29. Signature and title of Social Service Supervisor, or person assessing social factors in this field. Record date of signature as well.