SUGGESTIONS FOR COMPLETING FORM
1. The purpose of this form is to insure continuity of care in transfer from hospital to extended care facility or extended care facility to hospital.
2. The form is not intended to supply information of long-term nature.
3. Original should accompany patient with transfer. Carbon retained in patient's record.

INSTRUCTIONS:
This form has two sides. After completing front side, pull out carbon; turn form over; reinsert carbon face down. When writing, press firmly.

PATIENT TRANSFER FORM

(INTER-AGENCY REFERRAL)

PATIENT'S LAST NAME | FIRST NAME | MI | SEX ❍ M ❍ F | PRIMARY HEALTH INSURANCE NO. ❍ Medicare ❍ Medicaid ❍ Private

PATIENT'S ADDRESS (Street, City, State, Zip Code) | DATE OF BIRTH | RELIGION ❍ No religion designated

DATE OF THIS TRANSFER | TIME ❍ AM ❍ PM | FACILITY NAME, ADDRESS AND PHONE NO. TRANSFERRING TO | PHYSICIAN IN CHARGE AT TIME OF TRANSFER
This physician will care for patient after admission to new facility: ❍ No ❍ Yes

DATES OF STAY AT FACILITY TRANSFERRING FROM
ADMISSION | DISCHARGE

ALL PAYMENT SOURCE(S) FOR PATIENT
A. ❑ SELF OR FAMILY
B. ❑ PRIVATE INSURANCE
C. ❑ MEDICARE NO. _____
D. ❑ EMPLOYER OR UNION
E. ❑ MEDICAID NO. _____
F. ❑ OTHER (Explain) _____

LEVEL OF CARE DISCHARGING TO
❍ Skilled ❍ Nursing
❍ Residential
❍ Other:_____

NAME, ADDRESS AND PHONE NO. OF FACILITY TRANSFERRING FROM

CALL TO RECEIVING FACILITY: ❍ No ❍ Yes Name:_____ Date:_____ Time:_____ ❍ AM ❍ PM

NAME AND ADDRESSES OF ALL HOSPITALS AND SKILLED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS

NEXT CLINIC APPOINTMENT | DATE | TIME ❍ AM ❍ PM | ❑ CLINIC APPOINTMENT CARD ATTACHED

DATE OF LAST PHYSICAL EXAMINATION

RELATIVE OR GUARDIAN: Name | Address | Phone Number | Notified of transfer: ❍ No ❍ Yes

DIAGNOSES AT TIME OF TRANSFER
(a) Primary _____
(b) Secondary _____
(c) Infectious/Communicable Disease: ❍ No ❍ Yes, specify_____

EMPLOYMENT RELATED: ❍ No ❍ Yes
Patient aware of diagnosis: ❍ No ❍ Yes
Family/Representative aware of diagnosis: ❍ No ❍ Yes

VITALS AT TIME OF TRANSFER

Wt_____ T_____ P_____ AP_____ ❍ Reg ❍ Irreg

O_2 Sat_____ R_____ B/P_____

Check All That Apply

Disabilities
❑ Amputation
❑ Paralysis
❑ Contracture

Impairments
❑ Mental
❑ Speech
❑ Hearing
❑ Vision
❑ Sensation

Incontinence
❑ Bladder ❑ Bowel

Activity Tolerance Limitations
❍ None ❍ Moderate ❍ Severe

Fall Risk ❍ No ❍ Yes
Wander Risk ❍ No ❍ Yes
Choking Risk ❍ No ❍ Yes
Smoker ❍ No ❍ Yes

Potential for Rehabilitation
❍ Good ❍ Fair ❍ Poor

IMPORTANT MEDICAL INFORMATION

ALLERGIES ❍ NKA

❑ Food _____
❑ Drug _____
❑ Other _____

ADVANCE DIRECTIVES
❍ No ❍ Yes ❑ Copy Attached

CODE STATUS
❍ Full Code ❍ DNR ❑ DNR Order Attached

MEDICATIONS AND THERAPY AT TIME OF DISCHARGE

MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

❍ MAR attached to this form

THERAPY
❑ PT_____
❑ OT_____
❑ ST/SLP_____
❑ Respiratory_____
❑ Other_____

Influenza vaccination: Date:_____ Herpes Zoster vaccination: Date:_____
Pneumococcal vaccination (specify)_____ Date:_____
Tetanus/Tetanus-Diphtheria vaccination: Date:_____

Last BM:	Date:_____		
TB Test:	Date:_____	Type:_____	Result:_____
Chest X-Ray:	Date:_____	Result:_____	
CBC:	Date:_____	Result:_____	
Serology:	Date:_____	Result:_____	
Urinalysis:	Date:_____	Result:_____	

SUGGESTIONS FOR ACTIVE CARE

BED
Position in good body alignment and change position every _____ hrs.
Avoid _____ position
Prone position _____ times/day as tolerated.

SITTING
_____ hrs. _____ times/day.

WEIGHT BEARING
❍ Full ❍ Partial ❍ None on Right leg
❍ Full ❍ Partial ❍ None on Left leg

EXERCISES
Range of motion _____ times/day.
to _____ by
❑ patient ❑ nurse ❑ family
Stand _____ min. times/day.

LOCOMOTION
Walk _____ times/day.

SOCIAL ACTIVITIES
Encourage (❑ Group ❑ Individual) activities
(❍ within ❍ outside) home.

TRANSPORTATION
❍ Ambulance ❍ Car ❍ Car for handicapped
❍ Bus ❍ Other:_____

Signature/Title of Physician or Nurse: _____ Date: _____ Time: _____ ❍ AM ❍ PM

PATIENT INFORMATION

ADL STATUS
I = Independent
S = Supervision
A = Needs Assistance
U = Unable To Do

		I	S	A	U
Bed Activity	Turns	❍	❍	❍	❍
	Sits	❍	❍	❍	❍
Personal Hygiene	Face, Hair, Arms	❍	❍	❍	❍
	Trunk & Perineum	❍	❍	❍	❍
	Lower Extremities	❍	❍	❍	❍
	Bladder Program	❍	❍	❍	❍
	Bowel Program	❍	❍	❍	❍
Dressing	Upper Extremities	❍	❍	❍	❍
	Trunk	❍	❍	❍	❍
	Lower Extremities	❍	❍	❍	❍
	Appliance, Splint	❍	❍	❍	❍
Eating		❍	❍	❍	❍
Transfer	Sitting	❍	❍	❍	❍
	Standing	❍	❍	❍	❍
	Tub	❍	❍	❍	❍
	Toilet	❍	❍	❍	❍
Loco-motion	Wheelchair	❍	❍	❍	❍
	Walking	❍	❍	❍	❍
	Stairs	❍	❍	❍	❍

BED ❑ Low Mattress: ❍ Firm ❍ Regular
Other:_____
Side Rails: ❍ No ❍ Yes

BEHAVIOR ❑ Cooperative ❑ Oriented X _____
❑ Disruptive ❑ Belligerent ❑ Combative
❑ Senile ❑ Suspicious ❑ Withdrawn

MENTAL STATUS
❍ Alert ❍ Forgetful ❍ Confused

COMMUNICATION ABILITY

Able to make needs known	❍ No	❍ Yes
Can speak	❍ No	❍ Yes
Can hear	❍ No	❍ Yes
Can write	❍ No	❍ Yes
Understands speaking	❍ No	❍ Yes
Understands writing	❍ No	❍ Yes
Understands gestures	❍ No	❍ Yes
Understands English	❍ No	❍ Yes

If no, language spoken or understood:
_____
Needs interpreter: ❍ No ❍ Yes

DIET
❑ Regular ❑ Low Salt ❑ Diabetic ❑ Enteral
❑ Low Residue ❑ Other:_____
Fluid restriction: ❍ No ❍ Yes, _____
Needs consistency modification: ❍ No ❍ Yes,
specify:_____

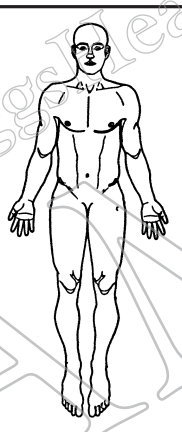
PATIENT USES
❑ Catheter - date of last change _____
Reason:_____
❑ Colostomy ❑ Urostomy ❑ Ileostomy
❑ Cane ❑ Crutches ❑ Prosthesis
❑ Walker ❑ Chair ❑ Geri Chair
❑ Hearing Aid ❍ Left ❍ Right ❍ Both
❑ Dentures: ❍ No ❍ Yes
❑ Upper ❑ Lower ❑ Partial_____

OTHER EQUIPMENT

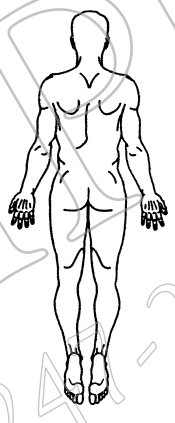
ADDITIONAL PERTINENT INFORMATION

Explain necessary details of care, diagnosis, medications, treatments, prognosis, teaching, habits, preferences, etc.
Therapists and social workers add signature and title to notes.

Orders for Isolation/Precaution: ❍ No ❍ Yes ❑ Contact ❑ Droplet ❑ Airborne ❑ Other:_____
Reason:_____



FRONT



BACK

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____
5. _____ 5. _____
6. _____ 6. _____
7. _____ 7. _____

SKIN STATUS

Use the figures to identify skin issues at time of transfer. Specify type of issue using this key and include measurements.

A = Abrasion
Br = Bruise
Bu = Burn
DTI = Deep Tissue Injury
L = Lesion
MASD = Moisture-Associated Skin Damage
PI 1 = Pressure Injury Stage 1
PI 2 = Pressure Injury Stage 2
PI 3 = Pressure Injury Stage 3
PI 4 = Pressure Injury Stage 4
Un = Unstageable
ST = Skin Tear
SU = Stasis Ulcer
SW = Surgical Wound
O = Other

❍ Wound Care Orders attached to this form

SOCIAL INFORMATION

Adjustment to disability, emotional support from family, motivation for self-care, socializing ability, financial plan, family health problem, etc.

Patient Involved in Discharge Planning: ❍ No ❍ Yes Bed Hold Policy Given To/Sent With Patient: ❍ No ❍ Yes