## PATIENT TRANSFER FORM

FACILITY: O No O Yes Name:       Date:       Time:       O PM         NEXT CLINIC APPOINTMENT       DATE       TIME       Date:       CLINIC         ADDAM       DATE       TIME       DATE       Time:       O PM         OLARD ARTACHED       DATE       TIME       DATE       Notified of transfer         QUARDIAN:       Address       Provide Stress       Notified of transfer       O No       Yes         QUARDIAN:       Address       Provide Stress       O No       Yes       O No       Yes         QUARDIAN:       Address       Patient awars of diagnosis:       O No       Yes       O No       Yes         QUARDIAN:       T       P       AP       O res       O No       Yes       No       Yes         VITLS AT TIME OF TRANSFER       MEDICATIONS AND THERAPY AT TIME OF DISCHARGE       THERAPY       O No       Yes         Vit												
INTERPITY # 4007495 (Status, City, Russ, Tay, Date)     INTERPITY     INTERPITY     INTERPITY       INTERPITY # 4007495 (Status, City, Russ, Tay, Date)     INTERPITY     INTERPITY     INTERPITY       INTERPITY	PATIENT'S LAST NAM	ЛЕ	FIRST N	AME		MIS		M OF	PRIMARY I	HEALTH INS	URANCE NO.	O Medicaid
Image: Data Control     Data Control       Image: Data Contro <td< td=""><td>PATIENT'S ADDRESS</td><td>(Street, City, State,</td><td>Zip Code)</td><td></td><td></td><td></td><td></td><td></td><td>н</td><td>RELIGI</td><td>ON O No reli</td><td></td></td<>	PATIENT'S ADDRESS	(Street, City, State,	Zip Code)						н	RELIGI	ON O No reli	
Image: Data Control     Data Control       Image: Data Contro <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>												
DAM     DM     The product allow and taken the bary interview in the bary interview and taken to the bary interview and taken to the comparison of the compar	DATE OF THIS TRANS	SFER	FACILITY NAME, ADDRES	S AND PHO	NE NO. TRANSFERRING TO			F	PHYSICIAN IN C	CHARGE AT	TIME OF TRANSF	ER
DAM     DM     The product allow and taken the bary interview in the bary interview and taken to the bary interview and taken to the comparison of the compar			-									
Dets or privative     ALL PRANT SOURCES TO NUMER     Image: constraints of the privative of the prive of the privative of the prive of the privative of the pr	TIME	2 AM 2 DM								vill care for p	atient after admiss	sion to new facility:
INVASIGNMENT EXEMU- ALLENGESCH       INVERTIGNED       INVERTIGNED <t< td=""><td>DATES OF STAY AT E</td><td></td><td>ALL PAYMENT SOURCE(S</td><td>) FOR PATI</td><td>ENT</td><td></td><td></td><td>0</td><td>O No O Yes</td><td></td><td>LEVEL OF CARE</td><td>DISCHARGING TO</td></t<>	DATES OF STAY AT E		ALL PAYMENT SOURCE(S	) FOR PATI	ENT			0	O No O Yes		LEVEL OF CARE	DISCHARGING TO
Image:	TRANSFERRING FRC	M		,		E. [		EDICAID NO.			O Skilled O Nu	
NAME_ADDRESS AND PHONE NO. OF PACING THIMAGEMENT OF HOM       Image: This pacework of all index to be determined the data of the data	ADMISSION	DISCHARGE		NCE D.	EMPLOYER OR UNION	E.		THER				
CALL D. RECENSING MADE TO USE ON the Name: DATE THE DATE DATE DATE OF LAST PHYSICAL EXAMINATION PROF. CLIM. APPOINTMENT DATE DATE DATE DATE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE DATE DATE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE DATE DATE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE DATE OF LAST PHYSICAL EXAMINATION DATE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE OF LAST PHYSICAL EXAMINATION PARAMENTAL APOINT RECENT THE OF LAST PHYSICAL EXAMINATION RECENTE OF TANLESEE DATE DATE OF LAST PHYSICAL EXAMINATION PARAMENTAL APOINT RECENT THE OF TANLESEE DATE OF LAST PHYSICAL EXAMINATION PARAMENT THE OF TANLESEE DATE PARAMENT THE OF TANLESEE DATE DATE PARAMENT THE OF TANLESEE DATE PARAMENT THE OF TANLESEE DATE PARAMENT THE OF TANLESEE DATE PARAMENT APOINT AND THE PARAMENT AT TIME OF DATE HARPY	NAME, ADDRESS AN	ID PHONE NO. OF F.							DRESSES OF A			CARE FACILITIES
FALLER 2016 Join Stein Name	,											
FALLER 2016 Join Stein Name												
NEXT CLING APPONTMENT     DATE     TIME     DAM     O PM     DAM     DAM <thdam< th=""> <thdam< <="" td=""><td>CALL TO RECEIVING</td><td></td><td></td><td></td><td>. —</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thdam<></thdam<>	CALL TO RECEIVING				. —							
DAM     DPM     Provide     Notice       BLANDEON     Notice     Notice     Notice     Notice       Origination     Annotation     Notice     Notice     Notice       Annotation     Notice			DATE					DATE	OF LAST PHY	SICAL EXAM		
BELATIVE CR     Norm     Addex     Provide filled of the and the adder of the			DAIL			APPO	OINTME	ENT				
DAMONDESS AT TIME OF TRANSPER       ONE O'NE         (a) Planzy	RELATIVE OR	Name	•					- CO	1	Phone Numb	er	
B) Primary Primary   b) Boconstrainty Primary   c) Social market Primary   c) More Constrainty Primary <t< td=""><td>GUARDIAN:</td><td></td><td></td><td></td><td></td><td></td><td><math>\neg \bigcirc</math></td><td></td><td>C</td><td><math>\leq</math></td><td></td><td></td></t<>	GUARDIAN:						$\neg \bigcirc$		C	$\leq$		
b) Secondary PankyRepresentative aware diagnosit:   (b) Mecicus/Communicable Decision: No   VTLS AT TIME OF TRANSFER PankyRepresentative aware diagnosit:   Nt T   P AP   Orsat R   Bladder Bowel   Amputation: District   Orsat R   Bladder Bowel   Amputation: District   Ortect All That Apply Incentifience   District Bladder   Brandition: District   Ortect All That Apply Incentifience   District Bladder   Brandition: District   Paraylis Non Orte   Speach Checking Bisk   Soboeth Checking Bisk   Soboeth Checking Bisk   Soboeth District   Drag District	DIAGNOSES AT TIME	OF TRANSFER				2	jo	/		EMPLOYM	IENT RELATED:	O No O Yes
(a) Interview       No       Yes, specify       Interview								(	)	Patient aw	are of diagnosis:	O No O Yes
VIALS AT TIME OF TRANSFER       Description         Wimperson       T       P       AP       Description         O Sat       R       BP       Description       Description         O Sat       R       BP       Description       Description         O Sat       R       BP       Description       Description         Onex All That Apply       Instantions       Description       Description       Description         Paralysis       O Non © Non © Non © Yes       Non © Yes       Non © Yes       O The         Contracture       Pall Risk       Smoker       O Mark attached to this form         Speech       O Hoir       O Hoir       O Mark attached to this form         Speech       O Hoir       Perspitatory       O ther         Production:       D Rocing Risk       Smoker       Perspitatory         Speech       O Hoir       Production: Date:       Hearing         Production:       D Rocing Risk       Smoker       Perspitatory         Other       O Hor       Concerter       Production: Date:       Production: Date:         Drog       Influenza vaccination: Date:       Hearing       PCV13 vaccination: Date:       Production: Date:         Drog       Inf	, <u> </u>					<u>}</u>				1		of diagnosis:
WL       T       P       AP       Drege       MEDICATIONS       THEPAPY         C Sat       R       B/P       037       StrSLP       037         C heck All That Apply       Incontinence       037       StrSLP       037         Deabilities       Bladder       Bowel       StrSLP       037         Amputation       Activity Tolerance Limitations       047       StrSLP       047         Parelysis       Anotytation       Activity Tolerance Devere       047       Respiratory       047         Contracture       No       Yeas       No       Yeas       No       Yeas       No       Yeas         Speech       No       Yeas       No       Yeas       No       Yeas       Preumococcil (PFSV23) vaccination: Date:       PCV13 vaccination: Date:       PV14         Induenza vaccination:       Date:       TteTest:       Date:       PResult:       Chest X-Ray: Date:       Result:       StoCoh Active Care       <			No O Yes, specify									
WL       T       P       AP       Orreg         Q2 Sat       R       BP       OF         Check AI That Apply       Incontinance       Disabilities       Disadder       Bowel         Approximation       Activity Tolerance Limitations       Pranaysis       None O Moderate O Severe       Office         Contracture       Eall Bids       Wander Risk       Disader       Office       Office         Speech       Ohoding Risk       Smaker       Hearing       O MAR attached to this form         Industry       East Bids       Smaker       Pre-woodcoactilitien: Date:       PCV13 vaccination: Date:       PCV13 vaccination: Date:         Influenza vaccination:       Date:       Teamus Teamus Toleravaccination: Date:       PCV13 vaccination: Date:       PCV13 vaccination: Date:         Influenza vaccination:       Date:       Title Teamus Teamus Toleravaccination: Date:       PCV13 vaccination: Date:       PCV13 vaccination: Date:         Order       ONA       Other       Chest X-Ray:       Date:       Title Teamus Te	VITALS AT TIME	OF TRANSFER		O Reg		MEDICATIC	JNSA				ANGE	
Q: SatRB/P	Wt 1	Г Р_	AP	_ O Irreg		$^{\prime}$		))				
Check All That Apply       Incontinence       Bladder	O2 Sat	R	B/P	<u>95</u>		<i>`</i>	7/2	/	- \ 🖃	/		
Disabilities D Bladder D Bowel   Amputation Activity Tolerance Limitations   Paralysis No or Moderate   Paralysis No or Wes   Mential Otoking Hisk   Mential Otoking Hisk   Speech No or Wes   Vision Potential for Rehabilitation   Seech No or Wes   Vision Potential for Rehabilitation   Seech NKA      Influenza vaccination: Date: Provide of Fair Or Poor Influenza vaccination: Date: Provide of Poir Or Poor Provide of Poir Or Poor Influenza vaccination: Date: Provide of Poor Provide of Poor Provide of Poor Provide of Poor Poor<	Check All That Ap	ply <u>Incontine</u>	nce	20/				<pre></pre>	- 0-	I P		
A Advivuty Tolerance Limitations   Paralysis   Poralysis   Contracture   Fall Risk   Wental   Choking Risk   Speech   No   Yes   Hearing   O'Yes   Hearing   O'No   Sensation   Good   Fail   Social Contracture   Hearing   O'No   Yes   Hearing   O'No    O'No   O'No <td></td> <td>Bladde</td> <td>r 🛛 Bowel</td> <td></td> <td colspan="3"></td> <td></td> <td colspan="4"></td>		Bladde	r 🛛 Bowel									
Contracture       Givene Givenere         Contracture       Fail Bisk       Wander Bisk         Impaiments       Oin No       Yes         Choking Risk       Smoker         Speech       Onko Ores         Vision       Description         Benation       Geod Or Fair         Sensation       Geod Or Fair         Drug       Influenza vaccination: Date:         Drug       Influenza vaccination: Date:         Drug       Ital BM:         Drug       Date:         Other       Testanus-TipEntheria vaccination: Date:         Result:       Date:         Other       Testanus-TipEntheria vaccination: Date:         Other       Chest X-Ray:         Other       Date:         Food       Urinalysis:         Other       DNR Order Attached         Urinalysis:       Date:         Result:       Result:         CoDE STATUS       Serology:         Full Code O DNR DNR Order Attached       Urinalysis:         Destion in good body alignment and       O Full O Partial O None on Right leg         Novid       position       Range of motion         Prone position       Itmes/day.         Signatu			1									
Impairments No Yes No Yes   Mental Choking filsk Smoker   Speech No Yes   Hearing No Yes   Vision Obtail for Rehabilitation   Sensation Good   Good Fair   Pool   Influenza vaccination: Date:   Important MEDICAL INFORMATION   ALLERGIES   NKA   Food   Drug   Other   ADVANCE DIRECTIVES   No   Yes   Other   Choes   Cop Status   O NR   ONR   ONS   Vestor   Date:   The secut:   Choes   Choes   Drug   Chest X-Ray:   Date:   Result:   Cop Status   ON O Yes   Optimized   Cop Status   Oblice   DNR   Order Attached   Divinal Order Attached   Urinalysis:   Date:   Result:   Cop Status   Subcections FOR ACTIVE CARE   Weight BEANING   Optimical or position   Prote position every   Ins.   Avoid   Prote position   Times/day.   Stand   On on Sight leg   Wait   Impained   Optimical or position   Range of motion   Impained   Impained	· ·						>		6	X)		
Mental Choking Risk Smoker   Peech No Yes   Weind Potential for Rehabilitation   Sensation Good   Sensation Good   Proug Influenza vaccination: Date:   Proug Porug   Other Other   Other Copy Attached   Obvorte Copy Attached   Obvorte Copy Attached   Suggestions For ACTIVE CARE WEIGHT BEARING   BED Piul O Partial O None on Right leg   Position in good body alignment and Full O Partial O None on Left leg   Avid position   Prore position Range of motion   TINS Patient   Influes Patient   Influes Patient   Influes Patient   Influes Patient   Signature/Title of Stand	Impairments							6	15			
Byeech No Yes No Yes   Hearing Potential for Rehabilitation O MAR attached to this form   Sensation Good Fair Poor   IMPORTANT MEDICAL INFORMATION Influenza vaccination: Date: PCV13 vaccination: Date:   Proumococcal (PPSV23) vaccination: Date: PCV13 vaccination: Date:   I Food Influenza vaccination: Date: PCV13 vaccination: Date:   I Food Itas BM: Date: Tetanus-Tetanus-Diphtheria vaccination: Date:   I TB Test: Date: Result:   Last BM: Date: Result:   CODE STATUS Chest X-Ray: Date:   I Full Code DNR DNR Order Attached   Urinalysis: Date: Result:   SuGESTIONS FOR ACTIVE CARE WEIGHT BEARING   VelGHT BEARING Valk   Influenze of motion Times/day.   Social in good body alignment and O Full   O Full Partial   No Full   Pone position Itimes/day.   Stand Influenze i family   Mind Influenze i family   Signature/Title of Stand<	Mental						. [					
Usion Detential for Rehabilitation   Sensation Good   IMPORTANT MEDICAL INFORMATION   ALLERGIES   NKA   Food   I food   Other   Other   ADVANCE DIRECTIVES   O No   Yes   CODE STATUS   FIL Code   O NR   INDUR Order Attached   WEIGHT BEARING   WEIGHT BEARING   Suggestrions For Active CARE   BED   Position   position <t< td=""><td>· ·</td><td></td><td></td><td>) Yes</td><td></td><td></td><td></td><td></td><td>_</td><td></td><td></td><td></td></t<>	· ·			) Yes					_			
IMPORTAIN MEDICAL INFORMATION       Influenza vaccination: Date:       Herpes Zoster vaccination: Date:         ALLERGIES       NKA       Period         Drug       Tetanus/Tetanus-Diphtheria vaccination: Date:       PCV13 vaccination: Date:         Drug       Tetanus/Tetanus-Diphtheria vaccination: Date:       PCV13 vaccination: Date:         Other       TB Test:       Date:       Tetanus/Tetanus-Diphtheria vaccination: Date:         ADVANCE DIRECTIVES       Chest X-Ray: Date:       Result:       Result:         ONO       Yes       Copy Attached       CBC:       Date:       Result:         OCDE STATUS       GBC:       Date:       Result:       Result:         O Full Code       DNR Order Attached       Virialysis:       Date:       Result:         SUGGESTIONS FOR ACTIVE CARE       WEIGHT BEARING       LOCOMOTION         BED       Full       Partial       None on Right leg       Walk <times day.<="" td="">         Prote position in good body alignment and       Full       Partial       None on Left leg       SOCIAL ACTIVITIES         Avoid      </times>	□ Hearing								O MAR attached to this form			
IMPORTANT MEDICAL INFORMATION       Pneumococcal (PPSV23) vacination: Date:PCV13 vacination: Date:	Sensation	O Good	O Fair O Poor	ŀ			2		_			
ALLERGIES ONAG       Tetanus/Tetanus-Diphtheria vaccination: Date:         Drug       Tataus/Tetanus-Diphtheria vaccination: Date:         Drug       TB Test:       Date:         Cher       Result:	IMPORTANT MEE	DICAL INFORMA	TION	>								
Insolution       Last BM:       Date:	ALLERGIES ON	VKA								/13 vaccina	ation: Date:	
Drug	Generation Food		<u></u>					ate:				
D Utner	Drug							Τ			Desult	
ADVANCE DIRECTIVES       CBC:       Date:       Result:	Other											
Serology:       Date:       Result:         CODE STATUS       Urinalysis:       Date:       Result:         Full Code       DNR       DNR Order Attached       WEIGHT BEARING       LOCOMOTION         BED       O Full       Partial       None on Right leg       Walk       times/day.         Position in good body alignment and change position every       hrs.       EXERCISES       EXERCISES       Encourage (□ Group □ Individual) activities         Avoid      position       Range of motion      by       TRANSPORTATION       O Ambulance       O Car of car for handicapped         SIgnature/Title of       Stand      min. times/day.       O Ambulance       O Car of Car for handicapped	ADVANCE DIREC	TIVES										
O Full Code O DNR DNR Order Attached       Urinalysis: Date: Result:	ONO OYes C	Copy Attached										
SUGGESTIONS FOR ACTIVE CARE       WEIGHT BEARING       LOCOMOTION         BED       0 Full 0 Partial 0 None on Right leg       Walk times/day.         Position in good body alignment and       0 Full 0 Partial 0 None on Left leg       SOCIAL ACTIVITIES         change position every hrs.       EXERCISES       Encourage ( □ Group □ Individual ) activities         Avoid position       Range of motion times/day.       ITRANSPORTATION         Prone position times/day.       to by       ITRANSPORTATION         SITTING       □ patient □ nurse □ family       ○ Ambulance ○ Car ○ Car for handicapped         hrs times/day.       Stand min. times/day.       ○ Bus ○ Other:			dor Attachad									
BED       O Full O Partial O None on Right leg       Walk times/day.         Position in good body alignment and       O Full O Partial O None on Left leg       SOCIAL ACTIVITIES         change position every hrs.       EXERCISES       Encourage ( □ Group □ Individual ) activities         Avoid position       Prone position times/day as tolerated.       EXERCISES       Encourage ( □ Group □ Individual ) activities         SITTING       □ patient □ nurse □ family       ○ Ambulance ○ Car O Car for handicapped       ○ Bus ○ Other:				WEIGUIT				Tiest				
Position in good body alignment and change position every hrs.       O Full O Partial O None on Left leg       SOCIAL ACTIVITIES         Avoid position       EXERCISES       Encourage ( G Group O Individual ) activities ( O within O outside ) home.         Prone position times/day as tolerated.       to by       TRANSPORTATION         SITTING hrs times/day.       D patient O nurse O family       Ambulance O Car O Car for handicapped         Signature/Title of       Stand min. times/day.       D Bus O Other:		OR ACTIVE CAR	E			iaht loa						
change position every hrs.       EXERCISES       Encourage ( Group I Individual ) activities (O within O outside ) home.         Avoid position times/day as tolerated.       EXERCISES       (O within O outside ) home.         SITTING hrs times/day.       Individual ) activities (I within O outside ) home.       Image of motion times/day.         Signature/Title of       Stand min. times/day.       Image of the second day.       Image of the second day.		odv alignment an	d			• •			vvaik	times/d	lay.	
Avoidpositionpositiontimes/day as tolerated.       Range of motiontimes/day.       () within O outside ) home.         Prone positiontimes/day as tolerated.       toby       ITRANSPORTATION         SITTINGhrstimes/day.       D patient D nurse D family       O Ambulance O Car O Car for handicapped         Signature/Title of       Standmin. times/day.       D Bus O Other:	-					entieg					D Individual )	activition
Prone position times/day as tolerated.       to by       TRANSPORTATION         SITTING hrs times/day.       □ patient □ nurse □ family       ○ Ambulance ○ Car ○ Car for handicapped         Signature/Title of       ○ Ambulance ○ Car ○ Car for handicapped       ○ Bus ○ Other:	Avoid		position			.,					,	activities
SITTING       □ patient       □ nurse       □ family       ○ Ambulance       ○ Car ⊙ Car for handicapped        hrs.      times/day.       Stand      min. times/day.       ○ Bus       O ther:         Signature/Title of         ○ Ambulance       ○ Car ⊙ Car for handicapped       ○ Ambulance	Prone position	times/day a	as tolerated.	-		-	ov		TRANSPOR	TATION		
hrstimes/day. Standmin. times/day. O Bus O Other: Signature/Title of O AM	SITTING					0					r O Car for h	andicapped
Signature/Title of	hrs	times/day.		·								
							D	ate:			Time:	

Form 882T Rev. 4/18 © BRIGGS, Des Moines, IA (800) 247-2343 Unauthorized copying or use violates copyright law. www.BriggsHealthcare.com

## ADL STATUS

## **PATIENT INFORMATION**

S = Super								
A = Needs U = Unab	s Assistance le To Do	I	S	Α	U			
	Turns		$\overline{\mathbf{O}}$		-			
Bed Activity		$\left  \begin{array}{c} 0 \\ 0 \end{array} \right $	-	0	0	ADDITIONAL PERTINENT INFOR Explain necessary details of care, diagnosis, medications, treatments, pro		
Activity	Sits	0	0	0	0	Therapists and social workers add signature an		
	Face, Hair, Arms	O	O	O	Ο	Orders for Isolation/Precaution: O No O Yes Contact Droplet	Airborno D Othor	
	Trunk & Perineum	O	O	Ο	Ο			
Personal Hygiene	Lower Extremities	O	O	O	$\mathbf{O}$	Reason:		
i i ygiono	Bladder Program	O	O	O	Ο			
	Bowel Program	Ō	Õ	Ō	Õ			
	Upper Extremities	Õ	Õ	Ŏ	$\overline{\mathbf{O}}$			
				-	-			
Dressing	Trunk	0	O	0	0			
	Lower Extremities	0	O	Ο	Ο			
	Appliance, Splint	O	O	O	Ο			
Eating		Ο	Ο	Ο	Ο			
	Sitting	Ο	Ο	$\mathbf{O}$	$\bigcirc$			
	Standing	ŏ	ŏ	$\left  \stackrel{\circ}{O} \right $	$\widetilde{O}$			
Transfer	Tub	_		$\left  \begin{array}{c} 0 \\ 0 \end{array} \right $	~			
		$\left  \begin{array}{c} 0 \\ 0 \end{array} \right $	$\left  \mathbf{O} \right $	-	O	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~	
	Toilet	0	0	$\odot$	$\odot$	ore COIDA		
	Wheelchair	O	O	O	O			
Loco- motion	Walking	O	O	O	O		$\leq$	
modoli	Stairs	$\mathbf{O}$	O	$\mathbf{O}$	$\mathbf{O}$			
BED DL	.ow Mattress: O F	irm (	O Re	qular			SKIN STATUS	
Other:			00	guiu			Use the figures to identify skin issues at time	
	ls: O No O Yes						of transfer. Specify type of issue using this	
Side Rai	is: O NO O res					(F) POS	key and include measurements.	
BEHAVIO	R Cooperative	Orien	ted X				A = Abrasion	
Disrup	otive 🗅 Belligerent 🗅	Com	bativ	е		MAN KINK	Br = Bruise	
Senile	Suspicious Wit	thdrav	wn				Bu = Burn	
MENTAL	STATUS				24		DTI = Deep Tissue Injury	
O Alert	O Forgetful O Confu	ised			)		L = Lesion	
	-		.<1	2	$\sim$	MA	MASD = Moisture-Associated Skin Damage	
	NICATION ABILITY	~1					$PI_1 = Pressure Injury Stage 1$	
	nake needs known	JQI		O Yes		$\langle 1 \rangle \langle 2 $	PI 2 = Pressure Injury Stage 2	
Can spe		°О I		O Yes			PI 3 = Pressure Injury Stage 3	
Can hear O No O Yes							PI 4 = Pressure Injury Stage 4	
Can writ	e	0	No	O Yes	S		Un = Unstageable	
Understa	ands speaking	0	No	O Yes	S	FRONT	ST = Skin Tear	
Understands writing O No O Yes				O Yes	S			
Understands gestures ( O No O Yes			O Yes	s		SU = Stasis Ulcer		
Understands English O No O Yes			O Yes	s	2	SW = Surgical Wound		
If no, language spoken or understood: 3.						3	O = Other	
						4 4		
Needs interpreter: O No O Yes					/	5 5		
				//				
			nteral					
· · · · · · · · · · · · · · · · · · ·						7 7	O Wound Care Orders attached to this form	
Fluid restriction: O No O Yes, Adjustment to disability, emotional support from family, motivation for self-care, socializing ability, financial plan, family health problem, etc.								
Needs c	Needs consistency modification: O No O Yes,							
specify:								
RESIDENT USES								
Catheter - date of last change								
		e						
Reason:								
	omy Urostomy II		omy					
	Crutches Prosthe							
	r 🛛 Chair 🖵 Geri Ch							
Hearing Aid O Left O Right O Both								
□ Dentures: ○ No ○ Yes □ Upper □ Lower □ Partial								
	ber 🗆 Lower 🖵 Par	tial						
OTHER E	QUIPMENT							
						Patient Involved in Discharge Planning: O No O Yes Bed Hold Policy	Given To/Sent With Resident: O No O Yes	
1						r adont involved in Disonarge r lanning. Onto Ones Ded 1000 P000		

**BRiGGS** Healthcare<sup>®</sup>