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 C. ❑ MEDICARE NO. _____ E. ❑ MEDICAID NO. _____

B. ❑ PRIVATE INSURANCE D. ❑ EMPLOYER OR UNION 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 (PPSV23) vaccination: Date:_____ PCV13 vaccination: 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:_____

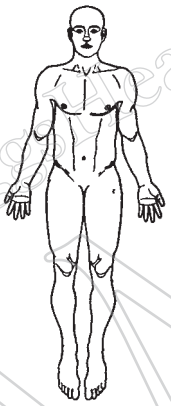
RESIDENT USES
❑ Catheter - date of last change_____
Reason:_____
❑ Colostomy ❑ Urostomy ❑ Ileostomy
❑ Cane ❑ Crutches ❑ Prosthesis
❑ Walker ❑ Chair ❑ Geri Chair
❑ Hearing Aid ❍ Left ❍ Right ❍ Both
❑ Dentures: ❍ No ❍ Yes
❑ Upper ❑ Lower ❑ Partial_____

OTHER EQUIPMENT

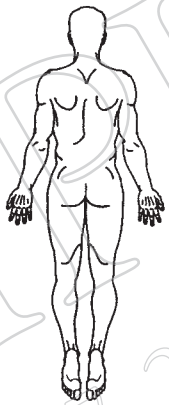
ADDITIONAL PERTINENT INFORMATION

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 Resident: ❍ No ❍ Yes