RESIDENT TRANSFER FORM

(INTER-AGENCY REFERRAL)

RESIDENT'S LAST NAME | FIRST NAME | MI | SEX ❍ M ❍ F | PRIMARY HEALTH INSURANCE NO. ❍ Medicare ❍ Medicaid ❍ Private ❍ VA ❍ Other:_____

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

DATE OF THIS TRANSFER | FACILITY NAME, ADDRESS AND PHONE NO. TRANSFERRING TO | PHYSICIAN IN CHARGE AT TIME OF TRANSFER

TIME OF TRANSFER ❍ AM ❍ PM

This physician will care for resident after admission to new facility: ❍ No ❍ Yes

DATES OF STAY AT FACILITY TRANSFERRING FROM — ADMISSION | DISCHARGE

ALL PAYMENT SOURCE(S) FOR CHARGES TO RESIDENT

A. ❑ SELF OR FAMILY C. ❑ MEDICARE NO. _____ E. ❑ MEDICAID NO. _____

B. ❑ PRIVATE INSURANCE D. ❑ EMPLOYER OR UNION F. ❑ OTHER (specify) _____

LEVEL OF CARE DISCHARGING TO ❍ Skilled ❍ LTC ❍ Home ❍ Assisted Living ❍ 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 RESIDENT 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, Relationship to Resident) | WAS THIS PERSON NOTIFIED REGARDING THIS TRANSFER? ❍ No ❍ Yes | WAS THIS PERSON (OR WAS THE RESIDENT) GIVEN INFORMATION ON HOW TO CONTACT THE STATE OMBUDSMAN? ❍ No ❍ Yes

DIAGNOSES AT TIME OF TRANSFER

(a) Primary (Reason for Transfer)_____

(b) Secondary_____

(c) Infectious/Communicable Disease: ❍ No ❍ Yes, specify_____

Employment related: ❍ No ❍ Yes

Resident 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_____

DIET, DRUGS AND OTHER THERAPY(IES) AT TIME OF DISCHARGE

Diet Order (specify):

Therapy(ies): (specify):

Current Medications	Strength & Frequency	Time of Last Dose
		❍ AM ❍ PM
		❍ AM ❍ PM
		❍ AM ❍ PM
		❍ AM ❍ PM
		❍ AM ❍ PM
		❍ AM ❍ PM
		❍ AM ❍ PM
		❍ AM ❍ PM

❍ MAR attached to this form

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

ALLERGIES ❍ NKA

❑ Food_____

❑ Drug_____

❑ Other_____

Influenza vaccine: Date:_____ Herpes Zoster vaccine: Date:_____

Pneumococcal vaccination (specify)_____ Date:_____

COVID-19 vaccine (specify)_____ Date:_____ Date:_____

Tetanus/Tetanus-Diphtheria vaccine: Date:_____

TB Test: Date:_____ Type:_____ Result:_____

Chest X-Ray: Date:_____ Result:_____

CBC: Date:_____ Result:_____

Serology: Date:_____ Result:_____

Urinalysis: Date:_____ Result:_____

ADVANCE DIRECTIVES
❍ No ❍ Yes ❑ Copy Attached

CODE STATUS
❍ Full Code ❍ DNR ❑ DNR Order Attached

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

ACTIVE CARE INFORMATION

BED

Position in good body alignment and

change position every _____ hours

Avoid _____ position

Prone position _____ times/day as tolerated

WEIGHT BEARING

Right leg: ❍ Full ❍ Partial ❍ None

Left leg: ❍ Full ❍ Partial ❍ None

EXERCISES

Range of motion _____ times/day

to _____ by

❑ patient ❑ nurse ❑ family

Stand _____ min. times/day

SITTING

_____ hrs. _____ times/day

LOCOMOTION

Walk _____ times/day

LAST BM

Date:_____

SOCIAL ACTIVITIES

Encourage (❑ Group ❑ Individual) activities

(❍ within ❍ outside) home

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

RESIDENT TRANSFER FORM (continued)

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	❍	❍	❍	❍

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:_____

COVID-19 testing results: ❑ Negative, Date(s):_____

❑ Positive, Date(s):_____

BED ❑ Low Mattress: ❍ Firm ❍ Regular

Other:_____

Side Rails: ❍ No ❍ Yes

BEHAVIOR ❑ Cooperative ❑ Oriented X _____

❑ Disruptive ❑ Belligerent ❑ Combative

❑ Senile ❑ Suspicious ❑ Withdrawn

❑ Other:_____

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(es)

❑ Walker ❑ Chair ❑ Geri Chair

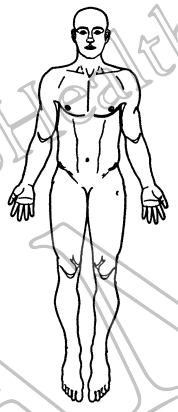
❑ Hearing Aid ❍ Left ❍ Right ❍ Both

❑ Dentures: ❍ No ❍ Yes

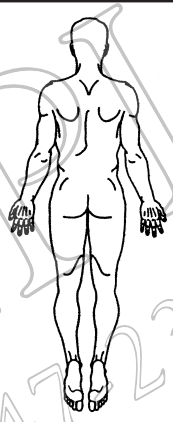
❑ Upper ❑ Lower ❑ Partial_____

❑ Oxygen ❍ PRN ❍ Continuous Flow_____

OTHER EQUIPMENT



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.

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