PATIENT TRANSFER FORM

(INTER-AGENCY REFERRAL)

INSTRUCTIONS: 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. When writing, press firmly.

PATIENT'S LAST NAME | FIRST NAME | MI | DATE OF BIRTH

DECISION MAKER ❑ Self ❑ Durable POA (Health Care Proxy)

Name:______

Relationship: ______

ADVANCE DIRECTIVES

Advance Directives: ❑ Yes, see attached ❑ No

DO NOT Resuscitate (DNR): ❑ Yes, see attached ❑ No

TRANSFERRING FACILITY

Facility Name:______

Contact Name: ______

Contact Number: ______

REASON FOR TRANSFER (may include brief medical history)

______

DIAGNOSES (include mental health)

(a) Primary ______

(b) Secondary ______

VITALS AT TIME OF TRANSFER

Date Taken:____/____/____ Time Taken:____ ❑ AM ❑ PM

Ht.____ Wt.____ BP:____ Temp.:____

Pulse:____ Resp:.____ Pulse Ox:____

ALLERGIES ❑ None known

Medication: ❑ Yes ❑ None known Food: ❑ Yes ❑ None known

Latex: ❑ Yes ❑ None known

AT RISK ALERTS ❑ None known

❑ Fall ❑ Harm to self ❑ Harm to others ❑ Seizure ❑ Elopement

❑ Aspiration ❑ Restraints ❑ Other______

ISOLATION/PRECAUTION

❑ None ❑ Contact ❑ Droplet ❑ Airborne

❑ MRSA Date___/___/___ Site:______

❑ VRE Date___/___/___ Site:______

❑ ESBL Date___/___/___ Site:______

❑ Other Date___/___/___ Site:______

History of MDRO: ❑ No ❑ Yes Date___/___/___

MDRO type:______

History of C-difficile? ❑ No ❑ Yes Date___/___/___

IV ACCESS

❑ PICC: Size____ Length____ # of Lumens____

❑ Heparin Lock ❑ Port-A-Catheter

SKIN CARE/ASSESSMENT

❑ No Wounds ❑ TAR attached ❑ See attached

Pressure Ulcer Risk Assessment:

Date of Assessment ___/___/___ Score ____ Scale (i.e., Braden)

Preventative Devices/Measures/Comments: ______

Wound Site and Type	Stage/Size	Characteristics	Treatment Plan	Recent Status
Site:____ ❑ Tear ❑ Trauma ❑ Surgical ❑ Vascular ❑ Diabetic ❑ Pressure related	1 2 3 4 US L W D	Odor: ❑ Yes ❑ No Drainage: ❑ Yes ❑ No Tunneling: ❑ Yes ❑ No Wound Color:____		❑ Date of onset ___/___/___ ❑ Improving ❑ Unchanged ❑ Worsening
Site:____ ❑ Tear ❑ Trauma ❑ Surgical ❑ Vascular ❑ Diabetic ❑ Pressure related	1 2 3 4 US L W D	Odor: ❑ Yes ❑ No Drainage: ❑ Yes ❑ No Tunneling: ❑ Yes ❑ No Wound Color:____		❑ Date of onset ___/___/___ ❑ Improving ❑ Unchanged ❑ Worsening
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Site:____ ❑ Tear ❑ Trauma ❑ Surgical ❑ Vascular ❑ Diabetic ❑ Pressure related	1 2 3 4 US L W D	Odor: ❑ Yes ❑ No Drainage: ❑ Yes ❑ No Tunneling: ❑ Yes ❑ No Wound Color:____		❑ Date of onset ___/___/___ ❑ Improving ❑ Unchanged ❑ Worsening

FOLLOW-UP CARE/APPOINTMENT

______

DOCUMENTS ATTACHED

❑ Current Medication/Treatment Administration Record

❑ Current Medication Reconciliation Record ❑ Face Sheet

❑ Immunization Records ❑ Current Physician Orders, # of pages____

❑ Other: ______

MEDICAL REPORTS, VALUES, PROCEDURES

(related to reasons for transfer)

Study Results (x-ray, EKG, CT, MRI, Scan, etc.): ❑ None ❑ See attached

Lab Values: ❑ None ❑ See attached

Surgical Procedures: ❑ None ❑ See attached

Signature of Physician or Nurse:______ Date:______

PROOF

Original: Keep with sending facility patient/resident records. Copy: Send with patient/resident at time of transfer.