Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary physicians name: \_\_\_\_\_\_\_\_\_\_\_\_\_

*May Place Resident Identification Sticker here*

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitals prior to transfer:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Temp:** | **Pulse:** | **Resp:** | **BP:** |
| **O2 sat:** | **Blood glucose:** | **Weight:** |  |

**Code Status** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main reason** for transferring to ER**/**Hospital **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LOC**(circle one): Alert/Confused/Unresponsive **Behaviors**(circle one): Pleasant/Combative/Agitated

**Precautions** (circle one): Standard/Contact/C. Diff/Droplet

**Primary family member to contact** (Name/Phone Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has family been notified of transfer**? Yes \_\_\_\_ No \_\_\_\_\_ Msg Left \_\_\_\_\_\_

**Normal transportation used** (MediVan, People’s, Family, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITIES OF DAILY LIVING** (circle appropriate – special notes in last column

|  |  |  |  |
| --- | --- | --- | --- |
| **Transfer Ability** | Independent  Assist of one with gait belt | EZ Stand/EZ lift  Bed bound |  |
| **Wheelchair** | Yes, all the time  Yes, for long distances only | No |  |
| **Walker** | Yes, all the time  Yes for transfers only | No |  |
| **Bed Mobility** | Independent  Assist of one | Assist of two |  |
| **Walking** | Independent  Supervision  Assist of one | Assist of two  Does not walk |  |
| **Dressing** | Independent  Supervision | Assist of one |  |
| **Grooming** | Independent  Supervision | Assist of one |  |
| **Eating** | Independent  Supervision  Tray Set Up | Partially Fed  Fully Fed  Tube Fed |  |
| **Bathing** | Independent  Participates with Assist | Fully bathed |  |
| **Bowel** | Continent  Incontinent | Colostomy  Iliostomy | Last Bowel Movement: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Bladder** | Continent  Incontinent | Foley Catheter  Suprapubic Catheter |  |

**Skin (circle all that apply):** Clear/Bruising/Rash/Skin Tear/Pressure Ulcer/Other

**Describe skin issues/location of skin issues**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccination information** (provide month/year)

**Influenza Vaccine \_\_\_\_\_\_\_\_\_\_ Pneumovax (PPV-23) ­­­­\_\_\_\_\_\_\_\_\_\_ Prevnar-13 \_\_\_\_\_\_\_\_\_\_\_**

**Valuables:** Glasses/Hearing Aid/Dentures Upper or Lower/Partial Upper or Lower/Ring/Watch

**Transferring facilities’ Nurse’s full name and phone number if more information is needed** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Documents Included with patient (check items sent with patient):**

POLST \_\_\_ Med/Treatment List \_\_\_ Living Will \_\_\_ Bed Hold \_\_\_ 3 days Prog Notes \_\_\_ Face Sheet \_\_\_

|  |
| --- |
| Upon arrival at your facility, please complete the following and fax back to the sending/transferring facility:  Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Arrival Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient admitted to room: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient under the care of (physician name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please fax this entire form to:  Transferring Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |