

MODEL TRANSFER FORM: NURSING FACILITY TO EMERGENCY DEPARTMENT/HOSPITAL

Date: _____ **Time of Transfer:** _____

The back of this form must be completed when the patient is transferred back to the nursing facility

Patient Information

Name: _____ Emergency Contact: _____
Primary Language: _____ Relationship to Patient: _____
Code Status: Full Code DNR Phone: _____
Notified of Transfer: Yes Date: _____ No
Name of Nursing Facility and Unit #: _____ Phone: _____
Address: _____
Reason for Transfer/Actions Taken Prior to Transfer: _____
Attending Physician: _____ Phone: _____

Vital Signs at Transfer

HT: _____ WT: _____ BP: _____ TEMP: _____
PULSE: _____ PULSE OX: _____ RESP: _____ Blood Sugar: _____
PAIN: Yes Rating 0-10 _____ SITE(S) of Pain: _____ No Pain
TREATMENT: _____

Baseline Mental Status

Alert Oriented Confused Demented Delirious Lethargic Comatose Agitated Assaultive Wanders
Does the Patient have decision-making capacity? Yes No
If not, who has authority to make decisions for the patient?
Name: _____ Phone: _____ Relationship to patient: _____

Attachments

Face Sheet MAR TAR (treatments) POS (doctor's orders) Pertinent Labs X-rays, EKGs, Scans Surgical Reports
 Copy of Signed DNR Order Original DDNR Advance Directive Skin Guide Other _____

At Risk For

None known Falls Skin Breakdown Seizures Communicable disease Aspiration
 Hypo/Hyperglycemia Harm to Self Harm to Others Other _____

Special Conditions

Skin Wounds: <input type="checkbox"/> Yes (Attach Skin Guide) <input type="checkbox"/> No Stage(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Wound VAC <input type="checkbox"/> Yes <input type="checkbox"/> No Needs a Special Mattress? <input type="checkbox"/> Yes <input type="checkbox"/> No	IV's in Last 14 days <input type="checkbox"/> Yes <input type="checkbox"/> No Foley Catheter <input type="checkbox"/> Yes Date inserted: _____ <input type="checkbox"/> No Oxygen Dependence: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal Cardiac Defibrillator <input type="checkbox"/> Other Implanted Devices (PICC Lines, Portacath, etc.)	Date of last pneumovac: _____ Date of last flu shot: _____ Date of last Tetanus shot: _____
Isolation Precautions: <input type="checkbox"/> None <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C-Diff <input type="checkbox"/> Other _____	Allergies: <input type="checkbox"/> Yes (List Below) <input type="checkbox"/> No _____ _____ _____
Special Diet (e.g. Thickened liquids) _____ _____	
Artificial Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No Baseline ADLs <input type="checkbox"/> Walking <input type="checkbox"/> Independent <input type="checkbox"/> Dependent <input type="checkbox"/> Transferring	

Print Name of Person Completing Form: _____ Phone: _____

Signature: _____ Date: _____

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Patient Name: _____

Is the Transfer Information Attached? Yes No (See "Attachments" Section Below)

IV Treatment: Yes No

Access: _____

Foley Catheter: Yes Date Inserted _____ No History of UTI: Yes No

Diagnosis/Findings:

Consultation(s):

Treatment/Continued Care Recommendations:

Copy of Treatment Documentation Attached: Yes No

Attachments Returned with Patient

Face Sheet MAR TAR (treatments) POS (doctor's orders) Pertinent ED Test Results

Copy of Signed DNR Order Original DDNR Advance Directive Skin Guide Other _____

Case Reviewed with Primary Care Provider (MD, NP, PA) Name: _____

Contact Info: _____

Medications

New Risks

Falls Skin Breakdown Seizures Communicable disease Aspiration Hypo/Hyperglycemia

Harm to Self Harm to Others Other _____

Skin Wounds: Yes (If yes, attach Skin Guide) No

Stage(s) 1 2 3 4 Needs a Special Mattress? Yes No

Emergency Department/Hospital Contact Information

Name/Address of Hospital: _____

Phone: _____

Print Name of Person Completing Form: _____ Phone: _____

Signature: _____ Date: _____