NURSING FACILITY TO HOSPITAL TRANSFER SHEET

Date _____

Patient name _____ Armband Identifier ❑ Yes ❑ No

Transferring facility _____ Transferring facility phone _____

Facility contact person _____

Receiving hospital _____ Hospital contacted? ❑ Yes ❑ No

Destination: ❑ emergency department   ❑ admitting   ❑ outpatient   ❑ clinic

Patient's primary physician _____ Has physician been notified? ❑ Yes ❑ No

Family member/guardian name _____ Family member/guardian contacted? ❑ Yes ❑ No

Phone number _____ Work number _____ Other number _____

The following information *must* be attached: ❑ **Medication sheet** ❑ **History and physical (H & P)** ❑ **Face sheet**

Does patient have - durable power of attorney?   ❑ Yes ❑ No

            - a living will?   ❑ Yes ❑ No

            - orders to limit emergency treatment?   ❑ Yes ❑ No

            - a legal guardian?   ❑ Yes ❑ No

            - a DNRCC?   ❑ Yes ❑ No

            - a DNRCC-Arrest?   ❑ Yes ❑ No

          Please provide docmuentation for each.

ADLs:	❑ independent	❑ assisted	❑ dependent	
Vision:	❑ no identifiable problem	❑ blind	❑ contacts and/or ❑ glasses (with patient?	❑ Yes ❑ No)
Hearing:	❑ with in normal limits	❑ hard of hearing	❑ deaf ❑ hearing aid (with patient?	❑ Yes ❑ No)
Mentation:	❑ alert.oriented	❑ combative	❑ confused ❑ unresponsive	
Speech:	❑ with in normal limits	❑ hard to understand	❑ aphasic ❑ equipment	
Feeding:	❑ independent	❑ assisted	❑ dependant ❑ dentures (with patient?	❑ Yes ❑ No)
Respiratory:	❑ Trach	❑ vent settings _____	❑ risk of aspiration	❑ Yes ❑ No

Allergies: _____

Skin assessment: _____

Vitals and baseline:

Temp _____ Pulse _____ Resp _____ BP_____ Age _____ Height _____ Weight _____

Date taken _____

Resistant organism?   ❑ Yes   ❑ No   ❑ MRSA ❑ VRE ❑ C-diff ❑ Other_____

Communicable disease?   ❑ Yes   ❑ No   ❑ airborne ❑ droplet ❑ contact Describe _____

Flu vaccine?   ❑ Yes   ❑ No   Date _____ Pneumonia vaccine? ❑ Yes ❑ No Date _____

Tetanus?   ❑ Yes   ❑ No   Date _____ Copy of immunization record attached? ❑ Yes ❑ No

Chief complaint/problem: _____

_____

Physician order(s): _____

_____

Nurse's signature _____ Date _____ Time _____ Phone _____

Private ambulance preference for return transfer _____ Phone _____

White - Hospital

Yellow - Nursing Home

GDAHA
GREATER DAYTON AREA
HOSPITAL ASSOCIATION
The Link to Quality Care

5/09