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 documentation 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 To reorder this form, contact GDAHA at (937) 228-1000 or visit www.gdaha.org.

Yellow - Nursing Home 5/09