PATIENT TRANSFER FORM

TRANSFERRING FACILITY/HOSPITAL

RECEIVING FACILITY | TRANSFER DATE

LOC ❑ SNF ❑ ICF | AGENCY | REVIEWER | DATE

LOC COMMENTS

❑ Hospital exemption included ❑ PASSAR results included

PATIENT INFORMATION

NAME (LAST / FIRST / MI) | PATIENT AUTHORIZED REPRESENTATIVE

ADDRESS | RELATIONSHIP | HOME PHONE NO. | WORK PHONE NO.

SOCIAL SECURITY NO. | DATE OF BIRTH | AGE | SEX M F

MARITAL STATUS S M W D SEP | ADMISSION DATE | MEDICARE | PRIVATE PAY Y N

MEDICAID / PENDING | MEDICAID / COUNTY | INS. NO.

MENTATION

❑ A&O ❑ Confused ❑ Forgetful ❑ Impaired Judgment
❑ Depressed ❑ Agitated ❑ Abusive ❑ Danger to Self or Others

DISCHARGE VITALS: T_____ P_____ R_____ BP_____

LAST CATHETER CHANGE DATE: | LAST BOWEL MOVEMENT DATE: | LAST I.V. DATE:

FUNCTIONING

1 Independent **2** Supervision - cues or assist 1 or 2 x 7 days **3** Limited Assist - physical help
4 Extensive Assist **5** Dependent - full staff performance

Bathing 1 2 3 4 5

Grooming 1 2 3 4 5

Bed Mobility - lying to side in bed 1 2 3 4 5

Medication Administration 1 2 3 4 5

Dressing 1 2 3 4 5

Toilet Use - uses toilet, transfers, cleanses 1 2 3 4 5

Eating 1 2 3 4 5

Transfer - between surfaces 1 2 3 4 5

Hearing (with appliance if used)
❑ Adequate ❑ Minimal difficulty ❑ Special situations only ❑ Highly impaired

Speech ❑ Clear ❑ Unclear ❑ None Write / Sign / Communication Board

Make Self Understood (expression)
❑ Always ❑ Usually ❑ Sometimes ❑ Rarely / never

Bladder Continence
❑ Continent - Complete Control
❑ Occasionally Incontinent - 2 or more times a week
❑ Incontinent - inadequate control
❑ Usually Continent - once a week or less
❑ Frequently Incontinent - daily

Bladder Appliances
❑ Pads / briefs ❑ External (condom) catheter ❑ Internal catheter

Bowel Status
❑ Continent - Complete Control
❑ Occasionally Incontinent - 2 or more times a week
❑ Incontinent - inadequate control
❑ Usually Continent - once a week or less
❑ Frequently Incontinent - daily

Bowel Rx ❑ Laxatives ❑ Enema ❑ Ostomy

ASSESSMENT AND RECOMMENDATIONS

PSYCHOSOCIAL INFORMATION:

COMMUNITY REFERRALS:

DNRCC ❑ YES ❑ NO | DNRCC-Arrest ❑ YES ❑ NO

LIVING WILL ❑ YES ❑ NO | DURABLE POWER OF ATTORNEY ❑ YES ❑ NO

LISW-S / LISW / LSW / RN SIGNATURE DATE

PAIN MANAGEMENT:

RANGE OF PAIN IN PAST 48 HOURS LOCATION (s)

DURATION ❑ Brief ❑ Intermittent ❑ Constant

CHARACTERISTIC ❑ Throbbing ❑ Sharp ❑ Burning ❑ Cramping ❑ Other:

EFFECTIVE PAIN RELIEF EFFORTS

NUTRITIONAL STATUS:

APPETITE PERCENTAGE

RESPIRATORY STATUS:

SKIN INTEGRITY:

INTACT ❑ YES ❑ NO

PRESSURE SORES ❑ YES ❑ NO DESCRIBE

PNEUMONIA VACCINE ❑ YES ❑ NO DATE

FLU VACCINE ❑ YES ❑ NO DATE

❑ MEDICATION RECORD ATTACHED ❑ YES ❑ NO

NURSE'S SIGNATURE DATE

WHITE - RECEIVING FACILITY

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

YELLOW - HOSPITAL CHART

GDAHA
GREATER DAYTON AREA HOSPITAL ASSOCIATION
The Link to Quality Care

PATIENT TRANSFER FORM

PRIMARY DIAGNOSIS:	SURGICAL PROCEDURES: DATE:
SECONDARY DIAGNOSES:	DATE:
	DATE:
	COMMUNICABLE DISEASES:
	MRSA: ❑ YES ❑ NO VRE: ❑ YES ❑ NO

PHYSICIAN ORDERS

NUTRITIONAL SOURCE / DIET:	THERAPIES: ❑ P.T.
TUBE FEED:	❑ O.T.
TPN:	❑ S.T.
ACTIVITY:	
ALLERGIES:	TRANSFER TECHNIQUES:
MEDICATIONS:	WEIGHT BEARING STATUS:
	TREATMENTS: ❑ RESPIRATORY
	❑ O_2 @ _____ lpm
	❑ Skin
	❑ Foley
	Diagnosis for Foley _____
	d / c Foley Date: _____
	LAB WORK:
	FOLLOW-UP APPOINTMENTS:
ADDITIONAL MEDICATION ORDERS ATTACHED: ❑ Yes ❑ No	

PHYSICIAN'S STATEMENT

H & P Dated: _____ Reviewed and Updated: _____

Do you expect the length of stay at nursing facility, LTAC, etc. to be less than 30 days ? ❑ Yes ❑ No

Prognosis: ❑ Good ❑ Fair ❑ Poor Rehab Potential: ❑ Good ❑ Fair ❑ Poor

It is recommended the patient level of care be: ❑ Intermediate ❑ Skilled ❑ Assisted Living ❑ LTAC ❑ Protective

I certify that the level of care is justified and that all information provided on this document is a timely and accurate reflection of the patient's condition.

_____ _____

Physician's Signature Date

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

GDAHA
GREATER DAYTON AREA HOSPITAL ASSOCIATION
The Link to Quality Care

7/10