PATIENT TRANSFER FORM

TRANSMITTING FACILITY/HOSPITAL

RECEIVING FACILITY

LOC

☐ SNF  ☐ ICF

AGENCY

REVIEWER

TRANSFER DATE

Hospital exemption included

PASSAR results included

PATIENT INFORMATION

NAME (LAST / FIRST / MI)

ADDRESS

SOCIAL SECURITY NO.

DATE OF BIRTH

AGE

SEX

M  F

MARITAL STATUS

ADMISSION DATE

MEDICARE

PRIVATE PAY

☐ S  ☐ M  ☐ W  ☐ D  ☐ SEP

MEDICAID / PENDING

MEDICAID / COUNTY

INS. NO.

DISCHARGE VITALS:

T

P

R

BP

LAST CATHETER CHANGE DATE:

LAST BOWEL MOVEMENT DATE:

LAST LV.

FUNCTIONING

BATHING

1  2  3  4  5

Bed Mobility - lying to side in bed

1  2  3  4  5

DRESSING

1  2  3  4  5

EATING

1  2  3  4  5

GROOMING

1  2  3  4  5

Medication Administration

1  2  3  4  5

Toilet Use - uses toilet, transfers, cleanses

1  2  3  4  5

Transfer - between surfaces

1  2  3  4  5

FUNCTIONING

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

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

Bowel Rx

☐ Laxatives

☐ Enema

☐ Ostomy

ASSESSMENT AND RECOMMENDATIONS

PSYCHOSOCIAL INFORMATION:

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

COMMUNITY REFERRALS:

NUTRITIONAL STATUS:

APPEITITE

PERCENTAGE

RESPIRATORY STATUS:

SKIN INTEGRITY:

INTACT

☐ YES  ☐ NO

PRESSURE SORES

☐ YES  ☐ NO

DATE

PNEUMONIA VACCINE

☐ YES  ☐ NO

DATE

FLU VACCINE

☐ YES  ☐ NO

DATE

LIVING WILL

☐ YES  ☐ NO

DURABLE POWER OF ATTORNEY

☐ YES  ☐ NO

☐ MEDICATION RECORD ATTACHED

☐ YES  ☐ NO

LISW-S / LISW / LSW / RN SIGNATURE

DATE

NURSE’S SIGNATURE

DATE

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WHITE - RECEIVING FACILITY

YELLOW - HOSPITAL CHART

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## PATIENT TRANSFER FORM

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<th>PRIMARY DIAGNOSIS:</th>
<th>SURGICAL PROCEDURES:</th>
<th>DATE:</th>
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<td>SECONDARY DIAGNOSES:</td>
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<tr>
<th>COMMUNICABLE DISEASES:</th>
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<tr>
<th>MRSA: ❑ YES ❑ NO</th>
<th>VRE: ❑ YES ❑ NO</th>
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<tr>
<th>NUTRITIONAL SOURCE / DIET:</th>
<th>THERAPIES:</th>
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<td>TUBE FEED:</td>
<td>❑ P.T.</td>
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<tr>
<td>TPN:</td>
<td>❑ O.T.</td>
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<th>ACTIVITY:</th>
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<th>TREATMENTS:</th>
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<td>❑ O₂ @ __________ lpm</td>
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| ❑ Skin |
| ❑ Foley |

Diagnosis for Foley ________________

d / c Foley Date: ________________

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<th>LAB WORK:</th>
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<th>FOLLOW-UP APPOINTMENTS:</th>
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<th>ADDITIONAL MEDICATION ORDERS ATTACHED:</th>
<th>❑ Yes ❑ No</th>
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## PHYSICIAN ORDERS

**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 _________________________

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7/10