



Continuity of Care **Acute Care Transfer Form**

Durable power of attorney

Living will

MOLST

Use this form for urgent/unplanned transfers for acute care.

End of life care/Code Status/Advance care planning *(Check all that apply and include copies of each document.)*

None MOLST Durable power of attorney Living will DNR

List of diagnoses

Vital signs

BP: HR: RR: Temp: pOx: Glucose: Time taken: am/pm

Allergies: Influenza (date): Pneumococcal (date): Tdap/Td (date):

Facility information

Sent to: _____
Sent from: _____
Date: _____ Unit: _____

Patient information

Last: _____ First: _____ MI: _____
DOB: _____ Male Female Other
Preferred language: English Other: _____

Facility contacts

Name: _____ Title: _____
Name: _____ Title: _____
Phone: () - Pager: () -

Emergency contact

Name: _____ Relationship: _____
Phone 1: () - Phone 2: () -
Guardian: Yes No DPOA: Yes No

Treating Provider *(at transferring facility)*

Name: _____ MD DO NP PA
Phone: () - Pager: () -

Resident status/level of care

Short-term/Rehab Long-term care Assisted living
Palliative Care: Yes No Hospice: Yes No

Patient psychiatric status

Voluntary Involuntary Conservatorship Constant observation

Reason for transfer *(see Situation Background Assessment Recommendation form for more details)*

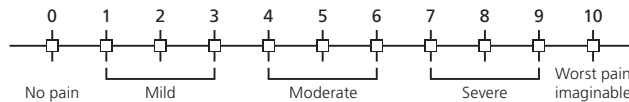
Baseline
Change (red flags)
Main concern

Last known normal (date): _____ Time: _____ am/pm

Baseline cognition

Alert: Yes No
Oriented X3: Yes No
Follow simple instructions Yes No

Baseline pain



Baseline ambulation

Independent With assistive device
 With assistance Not ambulatory

Devices/special treatments

Foley catheter
 Internal defibrillator
 IV/PICC line
 Pacemaker
 ITPN
 Other

Risk alerts

None Meds (see list) Limited/non-weight bearing
 Falls Harm to self Left
 Seizure Harm to others Right
 Aspiration Restraints
 Elopement Other: _____

Isolation/precaution *(currently)*

C-Diff MRSA TB
 ESBL CRE VRE
Other: _____
Site: _____
Comment: _____

Attached documentation and personal belongings: Shaded items required. Others provided if relevant. *(Check all that apply)*

Face sheet Current medications list or MAR Wound care sheet Bed hold policy
 Recent H&P SBAR/Nurse progress notes Relevant orders Relevant labs Relevant X-rays Other
 Glasses Contacts Hearing device: R / L Walker Cane Dentures: U L Partial Prosthetic:



Continuity of Care **Acute Care Transfer Form**

Use this form when transferring patient back to facility.

Form completed by: Name: _____ Title: _____ Signature: _____

Report called in by: Name: _____ Title: _____ **Report called in to:** Name: _____ Title: _____

Consultation notes *(consulting provider to complete and return with patient for facility or agency)*

continue on attachment if needed

Expectations for situation: Long-term problem Short-term problem

List of relevant diagnoses:

Vital signs

BP: _____ HR: _____ RR: _____ Temp: _____ pOx: _____ Glucose: _____ Time taken: _____ am/pm

Recommendations/orders for the medical necessity of continuance of professional care as specified

Documents attached: Additional notes and diagnoses New test results New prescription(s)/orders

Skilled nursing care Respiratory therapy Occupational therapy Follow-up visit required: Yes No
 Physical therapy Speech therapy

Appointment date: _____ Time: _____

Consulting provider

Name: _____ MD DO Other Signature: _____ Date: _____

Phone: () - Pager: () -

Attached documentation and personal belongings: Shaded items required. Others provided if relevant. *(Check all that apply)*

<input type="checkbox"/> Current medications list or MAR	<input type="checkbox"/> Wound care sheet				
<input type="checkbox"/> Recent H&P	<input type="checkbox"/> SBAR/Nurse progress notes	<input type="checkbox"/> Relevant orders	<input type="checkbox"/> Relevant labs	<input type="checkbox"/> Relevant X-rays	<input type="checkbox"/> Other
<input type="checkbox"/> Glasses	<input type="checkbox"/> Contacts	Hearing device: <input type="checkbox"/> R / <input type="checkbox"/> L	<input type="checkbox"/> Walker	<input type="checkbox"/> Cane	Dentures: <input type="checkbox"/> U <input type="checkbox"/> L <input type="checkbox"/> Partial <input type="checkbox"/> Prosthetic: