September 2018

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 pyschiatric status

☐ Voluntary ☐ Involuntary ☐ Conservatorship ☐ Constant observation

Reason for transfer *(see Situation Background Assessment Recomendation 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

0 1 2 3 4 5 6 7 8 9 10

No pain | Mild | Moderate | Severe | Worst pain imaginable

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
☐ Physical therapy ☐ Speech therapy

Follow-up visit required: ☐ Yes ☐ No
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)*

☐ Current medications list or MAR	☐ Wound care sheet				
☐ 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: