PATIENT TRANSFER FORM

(INTER-AGENCY REFERRAL) PART ONE

☐ Ka'u ☐ Hale Ho'ola Hamakua

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX ☐ M ☐ F	3. SOCIAL SECURITY NUMBER

4. PATIENT'S ADDRESS (Street, City, State, Zip Code)	5. DATE OF BIRTH	6. RELIGION

7. DATE OF THIS TRANSFER	8. FACILITY NAME AND ADDRESS TRANSFERRING TO	9. PHYSICIAN IN CHARGE AT TIME OF TRANSFER Will this physician care for patient after admission to new facility? ☐ YES ☐ NO

10. DATES OF STAY AT FACILITY TRANSFERRING FROM

11. PAYMENT SOURCE FOR CHARGES TO PATIENT

A. ☐ SELF OR FAMILY
B. ☐ PRIVATE INSURANCE
C. ☐ BLUE CROSS BLUE SHIELD
D. ☐ EMPLOYER OR UNION
E. ☐ PUBLIC AGENCY (Give name)
F. ☐ OTHER (Explain)

12-A. NAME AND ADDRESS OF FACILITY TRANSFERRING FROM

12-B. NAME AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS.

13. CLINIC APPOINTMENT DATE TIME ☐ CLINIC APPOINTMENT CARD ATTACHED

14. DATE OF LAST PHYSICAL EXAMINATION

15. RELATIVE OR GUARDIAN: Name Address Phone Number

16. DIAGNOSES AT TIME OF TRANSFER EMPLOYMENT RELATED: ☐ YES ☐ NO

17. Did patient receive assessment for flu and Pneumococcal vaccination status? ☐ Yes ☐ No
If no assessment done, conduct an assessment prior to transfer and administer vaccine if patient qualifies and consents. Did patient receive vaccination for flu this admission (Oct thru Feb) ☐ Yes ☐ No Pneumococcal in the past? ☐ Yes ☐ No

VITALS AT TIME OF TRANSFER

T _____ P _____ R _____ B/P _____

CHECK ALL THAT APPLY

Disabilities
☐ Amputation
☐ Paralysis
☐ Contracture
☐ Pressure Ulcer

Impairments
☐ Mental
☐ Speech
☐ Hearing
☐ Vision
☐ Sensation

Incontinence
☐ Bladder
☐ Bowel
☐ Saliva

Activity Tolerance Limitations
☐ None ☐ Moderate ☐ Severe

Patient knows diagnosis?
☐ Yes ☐ No

Potential for Rehabilitation
☐ Good ☐ Fair ☐ Poor

IMPORTANT MEDICAL INFORMATION
(State allergies if any)

ADVANCE DIRECTIVES
☐ Yes ☐ No ☐ Copy Attached

CODE STATUS

DIET, DRUGS, AND OTHER THERAPY
at Time of Discharge

(Physician, please sign below)

Date of Last B.M. _____

TB Test	Date _____	Type _____	Result _____
Chest X-Ray	Date _____	Result _____	
C.B.C.	Date _____	Result _____	
Serology	Date _____	Result _____	
Urinalysis	Date _____	Result _____	

SUGGESTIONS FOR ACTIVE CARE

BED
Position in good body alignment and change position every _____ hrs.
Avoid _____ position
Prone position _____ times/day as tolerated.

SITTING
_____ hrs. _____ times/day.

WEIGHT BEARING
☐ Full ☐ Partial ☐ None
on _____ Leg

EXERCISES
Range of motion _____ times/day.
to _____ by
☐ Patient ☐ Nurse ☐ Family
Stand _____ Min. _____ times/day.

LOCOMOTION
Walk _____ times/day.

SOCIAL ACTIVITIES
Encourage (☐ Group ☐ Individual) activities
(☐ Within ☐ Outside) home.

Transportation: ☐ Ambulance ☐ Car
☐ Car for handicapped ☐ Bus

Signature of Physician or Nurse _____ Date ____/____/____

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C. ☐ BLUE CROSS BLUE SHIELD
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(☐ Within ☐ Outside) home.

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☐ Car for handicapped ☐ Bus

Signature of Physician or Nurse _____ Date _____ / _____ / _____

PATIENT TRANSFER FORM
(INTER-AGENCY REFERRAL) PART TWO

PATIENT'S LAST NAME	FIRST NAME	MI	DATE OF BIRTH

PATIENT INFORMATION

SELF CARE STATUS

(Check level of ability. Write S in space if needs supervision only. Draw line across is inapplicable.)

		Independent	Needs Assistance	Unable To Do
Bed Activity	Turns			
	Sits			
Personal Hygiene	Face, Hair, Arms			
	Trunk & Perineum			
	Lower Extremities			
	Bladder Program			
	Bowel Program			
Dressing	Upper Extremities			
	Trunk			
	Lower Extremities			
	Appliance, Splint			
Feeding				
Transfer	Sitting			
	Standing			
	Tub			
	Toilet			
Loco-motion	Wheelchair			
	Walking			
	Stairs			

BED ☐ Low Mattress: ☐ Firm ☐ Reg.

Other _____

Side Rails: ☐ Yes ☐ No

BEHAVIOR ☐ Cooperative ☐ Oriented X_____

☐ Disruptive ☐ Belligerent ☐ Combative

☐ Senile ☐ Suspicious ☐ Withdrawn

MENTAL STATUS

☐ Alert ☐ Forgetful ☐ Confused

COMMUNICATION ABILITY

Able to make needs known

Can speak

Can hear

Can write

Understands speaking

Understands writing

Understands gestures

Understands English

If no, state language spoken or understood: ___

_____

DIET

☐ Regular ☐ Low Salt ☐ Diabetic ☐ Bland

☐ Low Residue ☐ Other _____

☐ Feeds Self ☐ Needs Help

☐ Partial Assist ☐ Total Assist

RESIDENT USES

☐ Appliance

☐ Catheter (date of last change ____ / ____ / ____

☐ Colostomy ☐ Cane ☐ Crutches ☐ Prosthesis

☐ Walker ☐ Chair ☐ Hearing Aid

☐ Dentures (Specify _____)

OTHER EQUIPMENT

☐ **DOCUMENT REASON(S) FOR TRANSFER BELOW:**

☐ **REASON(S) FOR TRANSFER SHARED WITH PATIENT / FAMILY**

☐ **ADDITIONAL PERTINENT INFORMATION** (Explain necessary details of care, diagnosis, medications, teaching, habits, preferences, etc. Therapists and social workers add signature and title to notes.) **SOCIAL INFORMATION** (Adjustment to disability, emotional support from family, motivation for self-care, socializing ability, financial plan, family health problem, etc.)

EDUCATION PROVIDED DURING HOSPITALIZATION OR AT TIME OF DISCHARGE TO PATIENT AND/OR FAMILY:

☐ Stroke - s/s, EMS activation, Prescribed medications, modifiable risk factors (diet, weight, blood pressure, etc.), smoking

☐ CHF: weight monitoring, activity, s/s, diet, medications, smoking

☐ AMI: smoking, s/s, activity, diet, medications, EMS activation

☐ Other: _____

_____

_____

_____

_____

_____

_____

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