Resident/Patient Continuum of Care Transfer Form

Type facility name here

Transfer to:_____

Patient Name: _____ Date:_____

Reason for Transfer: _____

_____

Allergies: (medications, dyes, food)_____

_____NKA_____

Attending Physician:_____

Relative / Guardian Notified: Yes ☐ No ☐

Name of Relative:_____Phone:_____

Transfer ambulance:_____

Attachments: please check

__ Face sheet
__ MAR/MD orders
__ Advance Directives
__ Treatment orders
__ Code Status
__ **P**hysician **O**rder **L**ife **S**ustaining **T**x
__ History &Physical
__ Pertinent labs
__ X-rays
__Bed Hold Policy
__Discharge Summary

Vital Statistics Taken:

Time taken:	Blood glucose: Time:
Respirations: O_2 Sat:	Height: Weight:
Pulse: BP:	**VRE:** Yes ☐ No ☐ Hx of ☐
Temp:	**MRSA**: Yes ☐ No ☐ Hx of ☐
Level on Pain Scale at time of transfer (please circle level number) **1 2 3 4 5 6 7 8 9 10**	

********** YOUR SPECIAL ATTENTION PLEASE **********

High risk for skin breakdown Please turn**** **Current Skin Breakdown**: No ☐ Yes ☐ (See tx sheet attached)

Vaccination History**: Pneumococcal Vaccine**: Yes ☐ date_____ Refused ☐

Flu Vaccine: Yes ☐ date_____ Refused ☐ **Tetanus**: Yes ☐ date:_____ Unknown ☐

PPD Test: Negative ☐ Positive ☐ **or** Chest X-Ray ☐

Result Date: _____Comments:_____

Meds: Whole ☐ Crushed ☐ Prefers meds with:_____

Safety Concerns: _____ **Hx of Falls**: No ☐ Yes ☐ **Risk For Falls:** No ☐ Yes ☐

Restraints: No ☐ Yes ☐ Type used: _____When used_____

Behavior Problems: No ☐ Yes ☐ Explain _____

Current Diet: _____

☐ Needs Assistance ☐ Feeds Self
☐ Thickened Liquid Consistency needed_____
☐ Feeding Tube
☐ Supplement

Elimination:

☐ Bladder Incontinence **Date** of UTI_____within 14 days
☐ Bowel Incontinence **Date** of last BM _____
☐ Catheter **Date** inserted or last changed _____
☐ Colostomy

Impairments / Disabilities: (Please check all that apply)

☐ Speech ☐ Contractures ☐ Mental Confusion ☐ Language Barrier
☐ Hearing ☐ Amputation ☐ Paralysis
☐ Vision ☐ Other _____

Patient Equipment/Belongings (Please check all that are sent with resident)

☐ None ☐ Glasses ☐ Right Hearing Aid ☐ Left Hearing Aid ☐ Upper Denture ☐ Lower Denture

Jewelry (please list):_____

Other (i.e., prosthesis)_____

Comments:_____

Report Called to:_____

_

Nurse Signature: _____(Legible) Phone #_____Date / Time:_____

Form designed in collaboration by Georgia's Cross Setting Meetings - facilitated by ***gmcf*** update 6/3/08