# INTER-FACILITY TRANSFER FORM

Patient Name _____ DOB _____

Transfer From _____

Date _____ Time _____

Transfer To _____

Dates of Stay _____ _____

Admitted Discharge

Physician _____ Phone _____

Will Follow Yes ☐ No ☐

Contact Person _____ Phone _____

Reason for Transfer _____

Diagnosis 1 _____

2 _____

**Patient Characteristics**

Height _____ Weight _____

B/P _____ Temp _____

Pulse _____ Resp _____

Incontinence

Bladder Yes ☐ No ☐

Bowel Yes ☐ No ☐

Date of Last B.M. _____

Fall Risk Low ____ Moderate ____ High ____

Aspiration Risk Low ____ Moderate ____ High ____

**Skin Status**

Rash _____ Excoriations _____

Pressure Ulcers _____ Status Ulcers _____

Bruises _____ Location _____

Wounds _____

Pain Program _____

Allergies _____

Diet Order _____

Psychosocial Info _____

Additional Comments _____

**Attach:**

Face Sheet ____ H & P or Progress Notes ____

Advanced Directives ____ Labs/X-Ray Reports ____

Physician Orders ____ Medication/Treatments ____

LTC Bed Hold ____ LTC Involuntary Transfer Notice ____

Hospital Transfer Notice ____ Hospital Therapy Orders ____

**Sensory/Language**

| Sight | Hearing | Communication |
|---|---|---|
| ____ Adequate | ____ Aid R/L | ____ Speaks Well |
| ____ Glasses | ____ Hard of Hearing | ____ Non Verbal |
| ____ Contacts | ____ Partially Deaf | ____ Aphasic |
| ____ Blind R/L | ____ Totally Deaf | ____ Garbled |
| | | ____ Can Read/Write |
| | | ____ Sign |

Primary Language _____

| Mental Status | Current | Baseline |
|---|---|---|
| Alert | | |
| Confused | | |
| Strikes Out | | |
| Oriented | | |
| Depressed | | |
| Comatose | | |
| Forgetful | | |
| Withdrawn | | |
| Noisy | | |
| Wanderer | | |
| Climbs Out of Bed | | |
| Other | | |

**Appliances/Prostheses** Sent = S Needed = N

Cane _____ Contact Lens _____

Dentures U/L _____ Glasses _____

Prosthesis _____ (type) _____

Crutches _____ Wheelchair _____

Walker _____ Other _____

Restraints (kind) _____

**Functional Levels**

| | Independent | Needs Assistance | Dependent |
|---|---|---|---|
| Bed Activity | | | |
| Personal Hygiene | | | |
| Dressing | | | |
| Eating | | | |
| Transfer | | | |
| Locomotion | | | |
| Weight Bearing | | | |
| Rehab Potential | Good | Fair | Poor |
| Activity Tolerance | Good | Fair | Poor |

Name of Person Completing Form _____ Phone _____

Called To _____ Phone _____

Faxed To _____ No. _____

Follow Up Clinic Appointment _____

Date Time

Signature _____ Date _____

**INSTRUCTIONS FOR USE OF**
**INTER-FACILITY TRANSFER FORM**

The transfer form is to provide essential, accurate information that will facilitate care planning for the patient/resident, that incorporates identification of previous status from which to develop goals.

| | | |
|---|---|---|
| Patient/Resident Name | | Name of patient/resident |
| Transfer - | From:<br>To: | Facility name<br>Date and time leaving facility |
| Dates of Stay | | Dates of stay in transferring facility |
| Physician<br>Phone number | | Physician who followed patient in transferring facility |
| Will Follow | | Will the physician who treated patient in transferring facility treat patient in the receiving facility? |
| Reason for Transfer (to hospital)<br>(To NH) | | Describe: e.g., pain R hip<br>Rehab R hip ORIF |
| Diagnosis | (1)_____<br>(2)_____ | Most recent diagnoses as listed on transferring medical record |
| Patient Characteristics<br>V.S. | | Most recent weight/height<br>Vital Signs @ time of transfer |
| Incontinence | | Usual state as assessed in transferring facility |
| Fall Risk | | At time of transfer |
| Aspiration Risk | | At time of transfer |
| Skin Status | | At time of transfer, size, stage, location of ulcers under Comments |
| Pain Program | | During stay in transferring facility |
| Allergies | | As listed on medical record (drug or food) |
| Diet Order | | Should reflect consistency required to nourish at time of transfer (i.e., pureed, 1200ADA, honey thickened liquids) |

| | |
|---|---|
| Psycho social/Contact person | Family contact - significant other/any specific family interaction<br>Mental Health intervention |
| Additional Comments | i.e., resides on locked unit, certified to specific facility |
| Attach | **May check and attach if appropriate**. (1) Face sheet must accompany patient resident. (2) Advanced directives - copies of all orders and living will, etc. Physician orders current. |
| Orders for Care Attached | Orders to be used for care in receiving facility. Physician orders current. Most recent MAR/hospital medication records for past 7 days.<br>*If therapy checked, orders should accompany patient/resident on attached document |
| Sensory/Language | Describe as found on M.D.S. for nursing home. Describe as documented in Medical Record for hospital |
| Mental Status | Describe at time of transfer and describe usual status previous to transfer |
| Appliances | List appliance needed and indicate if sent with patient/resident. Describe kind and frequency of use of restraint, (i.e., side rails, kind of chair, waterbed, etc.). |
| Functional Levels | *Check item to indicate patient/resident's most dependent state.<br>*Rehab potential - best assessment (Circle response)<br>*Activity tolerance refers to patient/resident endurance or ability to complete tasks. (How long do you believe this person can be active?). (Circle response) |
| Signature and Date | Person completing form who will serve as telephone or fax contact between facilities. **A phone call in either direction would be recommended** to clarify patient/resident status. |
| Other - describe | Telephone call between providers. **Identify the person** who is unit/wing/station/Case Manager, Admission Coordinator/DON. You are requested to call the unit manager or nurse on unit. Transfer form will be faxed **or** sent with patient to the receiving facility.<br>Review payment source e.g., is the facility able to accommodate, managed care, Medicaid certified, etc. |