PATIENT TRANSFER FORM

(INTER-AGENCY REFERRAL)

Index: 6080.000
Addendum: #2
Effective December 2, 1998

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
ADMISSION | DISCHARGE

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

(a) Primary

(b) Secondary

EMPLOYMENT RELATED: ☐ YES ☐ NO

VITALS AT TIME OF TRANSFER

T _____ P _____ R _____ B/P _____

CHECK ALL THAT APPLY

Disabilities
- ☐ Amputation
- ☐ Paralysis
- ☐ Contracture
- ☐ Pressure Ulcer

Incontinence
- ☐ Bladder
- ☐ Bowel
- ☐ Saliva

Activity Tolerance Limitations
☐ None ☐ Moderate ☐ Severe

Impairments
- ☐ Mental
- ☐ Speech
- ☐ Hearing
- ☐ Vision
- ☐ Sensation

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. _____

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.

Transporation: ☐ Ambulance ☐ Car
☐ Car for handicapped ☐ Bus

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

RESIDENT INFORMATION

SELF CARE STATUS

(Check level of ability. Write S in space if needs supervision only. Draw line across if 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	YES	NO
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

ADDITIONAL PERTINENT INFORMATION

(Explain necessary details of care, diagnosis, medications, treatments, prognosis, 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.)