INTERAGENCY TRANSFER FORM

PATIENT'S LAST NAME	FIRST NAME	M.I	DATE OF BIRTH	AGE	SEX [ ]M [ ]F	MEDICAL RECORD NUMBER

DISCHARGE ADDRESS (N.H , HOSPITAL, HHC) | PHONE #

TRANSFERRED FROM | NURSING UNIT | ADMISSION DATE | TRANSFER DATE

PHYSICIAN IN CHARGE AFTER TRANSFER | Contact #

PRIMARY DIAGNOSIS AT DISCHARGE

SECONDARY DIAGNOSIS AT DISCHARGE (INCLUDE SURGICAL PROCEDURES)

RESOLVED DIAGNOSIS AT DISCHARGE

ACCOMPANYING CHART RECORDS

- [ ] Demographics / Facesheet
- [ ] H&P / Consults
- [ ] Labs
- [ ] X-ray
- [ ] Living Will / Advance
- [ ] Directive
- [ ] Vital Signs Report
- [ ] I&O by method Report
- [ ] OT/PT/Speech Notes
- [ ] OP Report
- [ ] Pathology
- [ ] MAR / EMAR
- [ ] Orders
- [ ] Medication Reconciliation Form
- [ ] Physician Notes
- [ ] Discharge Summary
- [ ] DNR request form
- [ ] Dietary
- [ ] WOC Notes

ACTIVITY LEVEL | **DIET**

[ ] Full Code [ ] DNR [ ] DNI

Allergies / Latex Sensitivity [ ] On H & P

REQUIRED DISCHARGE INFORMATION

Overall Status [ ] Improving [ ] Stable [ ] Unstable [ ] Deteriorating [ ] Terminal

Initiate / Resume Nursing Home Standing Orders [ ] Yes [ ] No

[ ] Skilled Short Term Care - Est. # Wks _____ [ ] Skilled Long Term Care

Discharge Services / Referrals

[ ] Hospice [ ] Stoma Therapy Evaluate and Treat

[ ] Physical Therapy Evaluate and Treat [ ] Occupational Therapy/Evaluate and Treat

[ ] Speech Therapy Evaluate and Treat [ ] Other _____

[ ] Cardiac Rehab [ ] Diabetic Center

Discharge Potential: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Rehab Potential: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Home Care Services [ ] Yes [ ] No

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply)

[ ] Nursing [ ] Physical Therapy [ ] Speech language pathology - To provide the following care/treatments: _____

[ ] I certify that this patient is under my care and that I, a nurse practitioner or physician's assistant working with me, had a face to face encounter that meets the physician face to face encounter requirement with this patient.

[ ] Further I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort to leave home and unable to leave home unassisted)

OTHER PHYSICIAN ORDERS/TREATMENTS

[ ] See "Medication Reconciliation Form" for Medications
(SCHEDULE II NARCOTIC MEDS REQUIRE HARD COPY OF RX)

[ ] Glucometer (frequency) _____

[ ] Oxygen Order:

History and Physical has been reviewed and is current

_____ _____ _____

Physician Signature **Date** **Time**

Use Stat Line to Dictate*

REASON FOR TRANSFER/SYNOPSIS OF HOSPITALIZATION (NURSING):

Special Equipment/devices:

Vaccinations Flu Vaccine Given: [ ] Yes [ ] No Date Tetanus Toxoid Given: _____
Pneumococcal Vaccine Given: [ ] No [ ] Yes, Date: _____

ACTIVITIES OF DAILY LIVING:

DRESSING: [ ] Ind. [ ] Assist. [ ] Unable

GROOMING: [ ] Ind. [ ] Assist. [ ] Unable

BATHING: [ ] Ind. [ ] Assist. [ ] Unable

EATING: [ ] Ind. [ ] Assist. [ ] Unable Supplement/Type_____
Chokes Easily [ ] Yes [ ] No [ ] Tube feeding/NG/Gastrostomy or Jejunostomy **Time of last feeding:**_____

WALKING: [ ] Ind. [ ] Assist. [ ] Unable
Device (circle): Cane Walker Wheelchair Geri-chair Crutches

FALL RISK [ ] Yes [ ] No

CHAIR TRANSFER: [ ] Ind. [ ] Assist. [ ] Unable [ ] Hoyer

TURNING IN BED: [ ] Ind [ ] Assist.

BED TRANSFER: [ ] Ind. [ ] Assist. [ ] Unable [ ] Siderails [ ] Restraints - Type_____
[ ] Paralysis [ ] Contractures [ ] Amputation - Type

BLADDER: [ ] Continent [ ] Incontinent [ ] Catheter - Type [ ] Urostomy
[ ] Bladder Program (describe) _____

BOWEL: [ ] Continent [ ] Incontinent [ ] Colostomy / Ileostomy
Date Last BM: _____ [ ] No BM while hospitalized, Reason _____
Bowel Program (describe)_____

SKIN CONDITION: [ ] Good [ ] Skin Tear (describe) _____ [ ] Surgical wound (describe)_____
[ ] Rash (describe)_____ [ ] Dermal ulcer (describe):_____ Braden Scale: _____
(If 18 or less, discharge skin Assessment __ Y __ N
[ ] Other (describe):_____ **Treatments:**_____

INFECTION / CONTACT PRECAUTIONS [ ] VRE [ ] MRSA [ ] C-Diff [ ] Other

COMMUNICATION LIMITATIONS: [ ] Blind [ ] Deaf [ ] HOH [ ] Aphasia (describe)_____
[ ] Language Barrier [ ] Other:_____

MENTAL STATUS: [ ] Alert [ ] Disoriented/confused (circle) [ ] Directs own care [ ] Comatose
[ ] Describe any safety concerns:_____

BEHAVIOR: [ ] Withdrawn [ ] Drowsy [ ] Forgetful [ ] Noisy [ ] Wanders
[ ] Combative [ ] Appropriate [ ] Other_____

VALUABLES ACCOMPANY PATIENT [ ] Glasses [ ] Hearing Aid(s) [ ] Prosthesis
[ ] Partial [ ] Dentures (circle): Upper Lower [ ] Watch [ ] Ring [ ] Contacts
[ ] Walker [ ] Crutches [ ] Cane [ ] Wheelchair [ ] Other _____

VITAL SIGNS AT TIME OF TRANSFER: BP: T: P R: Weight: **Discharge Pain Rating 0 1 2 3 4 5 (circle)**

PSYCHOSOCIAL INFORMATION:

Name of Family Member Notified of Transfer:

NURSE'S SIGNATURE PHONE DATE / TIME