Transfer Form

Patient Information

Last name: _____ First name: _____

Date of birth: __/__/__ Age: _____ Sex: ☐ M ☐ F Date of transfer: __/__/__

Transferring facility:	**Receiving facility:**
Contact name:	**Contact name:**
Phone number:	**Phone number:**
Fax number:	**Fax number:**
Nurse giving report:	**Responsible provider for first 24 hours after transfer:**
Time of report:	**Report given to (name):**

Emergency contact:

Emergency contact relationship to patient:

Emergency contact number:

Reason for transfer:

Primary diagnosis:

Problem list:

Overall goal for patient/prognosis:

Rehab potential: ☐ Good ☐ Fair ☐ Poor

Wound care: _____

See attached: ☐ Physician orders ☐ Wound flow sheet ☐ Nurse's notes

Vital signs at time of transfer: BP: _____ P: _____ T: _____ RR: _____

O_2 sat: _____ Height: _____ Weight: _____

Allergies: _____ ☐ No known allergies (NKA)

Code status: ☐ Full code ☐ DNR ☐ DNI | Advance directive: ☐ No ☐ Yes, attached

High risk for falls: ☐ No ☐ Yes

☐ Tab alarm ☐ Floor alarm ☐ Bed alarm ☐ Sensor alarm ☐ Lap belt ☐ Motion detector

Other safety devices needed: _____

Additional safety concerns: ☐ Aspiration ☐ Seizure ☐ Wander ☐ Other: _____

Infection: ☐ No ☐ Yes, describe: _____

Isolation: ☐ No ☐ Yes ☐ Contact precautions ☐ Droplet precautions ☐ Airborne precautions

Other infection control: _____

Pain assessment: ☐ None ☐ Acute ☐ Chronic ☐ Intermittent ☐ Sharp ☐ Dull

☐ Other: _____

Location: _____ Intensity (1–10): _____ Time of last assessment: _____

Time of last pain med: _____ Pain med administered (dose/route): _____

Mental status: ☐ Alert ☐ Oriented ☐ Non-verbal ☐ Unresponsive ☐ Confused

☐ Other: _____

Behavioral status: ☐ Combative ☐ Requires redirection ☐ Requires verbal cues ☐ Withdrawn

☐ Disruptive behavior, describe: _____ ☐ Other: _____

Communication needs/sensory deficits: ☐ Blind ☐ Glasses ☐ Visual field cut

☐ Deaf ☐ Hard of hearing (HOH) ☐ Hearing aid

☐ Aphasia, describe: _____

☐ Interpreter, language: _____ Devices used: _____

Skin and body assessment: ☐ Skin intact ☐ At risk ☐ Skin not intact
Site: _____ Discovery date: __/__/__

Special diet: ☐ No ☐ Yes, describe: _____
Dentures: ☐ None ☐ Upper ☐ Lower ☐ Partial
Tube feedings: ☐ No ☐ Yes, rate/frequency: _____
Formula: _____

Discharge medications (dose/frequency/route): ☐ See med reconciliation form
☐ See discharge med list ☐ N/A
Recent medications received and date/time last administered: *Please attach copy of current Medication Administration Report (MAR)*
Immunization dates: Influenza: __/__/__ Pneumococcal: __/__/__
Tetanus/diphtheria (Td): __/__/__ *or* Tetanus, diphtheria, & acellular pertussis (TDAP): __/__/__
TB skin test: __/__/__ Result: _____
Two-step TB skin test, 2nd date: __/__/__ Result: _____
Recent labs: *Please attach copy of current labs*

Activities of daily living: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory
☐ Cane ☐ Wheelchair ☐ Walker ☐ Other: _____

Assistive devices: ☐ Reacher/grabber ☐ Shoe horn ☐ Sock aid ☐ Leg lifter
☐ Other: _____

Transferring: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory

Bathing: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory

Dressing: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory

Eating: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory

Bed mobility: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory

Toileting: ☐ Independent ☐ Supervision ☐ Limited assistance
☐ Extensive assistance ☐ Non-ambulatory

Bowel/Bladder: ☐ Continent ☐ Incontinent ☐ Ostomy ☐ Briefs/pads worn
Date of last BM: __/__/__

Foley catheter: ☐ No ☐ Yes Insert Date: __/__/__ Removal Date: __/__/__

Respiratory care: Oxygen: ☐ No ☐ Yes, type/rate: _____
Date of last treatment: __/__/___ Time: _____

Packing/drains: ☐ No ☐ Yes, type: _____
Date of last treatment: __/__/___ Time: _____

IV/central line: ☐ No ☐ Yes, type/location: _____
Rate: _____ Insert date: __/__/___

Valuables sent with patient:

Form completed by: _____ Date: __/__/__ Time: _____
Time of patient transfer: _____