

NURSING FACILITY TO HOSPITAL TRANSFER SHEET



Date:		DOB:	
Resident's last name:		Resident's first name:	Middle:
Transferring facility:		Transferring facility phone:	
Receiving hospital:		Hospital Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Destination: <input type="checkbox"/> emergency department <input type="checkbox"/> admitting <input type="checkbox"/> outpatient <input type="checkbox"/> clinic			
Resident's primary physician:		Has physician been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family member's/guardian name:		Family member/guardian contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Phone number:	Work number:		Other number:

The following information *must* be attached: Medication sheet History and physical (H & P) Face sheet
 (Attach documentation of last dose administered of medications)

Does patient have:		
Durable power of attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valuables with resident?
A living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clean/Dry when leaving?
Orders to limit emergency treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A legal guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A Do Not Resuscitate Comfort Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A DNRCC arrest?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please provide baseline documentation for each

ADLs: <input type="checkbox"/> independent <input type="checkbox"/> assisted <input type="checkbox"/> dependent	
Vision: <input type="checkbox"/> no identifiable problem <input type="checkbox"/> blind <input type="checkbox"/> contacts and/or <input type="checkbox"/> glasses	Glasses with resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing: <input type="checkbox"/> within normal limits <input type="checkbox"/> hard of hearing <input type="checkbox"/> deaf <input type="checkbox"/> hearing aid	Hearing aid with resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mentation: <input type="checkbox"/> alert oriented <input type="checkbox"/> combative <input type="checkbox"/> confused <input type="checkbox"/> unresponsive	
Speech: <input type="checkbox"/> within normal limits <input type="checkbox"/> hard to understand <input type="checkbox"/> aphasic <input type="checkbox"/> equipment	
Feeding: <input type="checkbox"/> independent <input type="checkbox"/> assisted <input type="checkbox"/> dependant <input type="checkbox"/> dentures	Dentures with resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet: <input type="checkbox"/> Need Assist:	
Allergies:	

Vitals and baseline:

Temp:	Pulse:	Resp:	BP:	Age:	Height:	Weight:
Time taken:		Pox:	O2:	Pain Level:	Location:	
Resistant organism? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes: <input type="checkbox"/> MRSA <input type="checkbox"/> C-Diff <input type="checkbox"/> VRE <input type="checkbox"/> other			
Communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, describe?			
Flu Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Pneumonia vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			
Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Copy of immunization record attached? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Private ambulance preference for return transfer: _____ Phone: _____

Chief complaint/problem? _____

Physician order(s): _____

Nurse's Signature: _____ Most recent hospital stay within 90 days: _____

Print: _____

Date: _____ Time: _____

Phone: _____