APPENDIX C
PATIENT INFORMATION TRANSFER FORM

Patient Name ____
Transferred From Facility/Unit ____________________________________
Facility Transferred to ____________________________________
Transfer Date ____________________________________
ADM and Discharge Diagnosis ____________________________________
Allergies ____________________________________

SSN ____________________________________
DOB ____________________ Sex ____________________
Religion ____________________________________
Pt. Address ____________________________________
Next of Kin ____________________________________
Phone ____________________________________

☐ Yes ☐No DNR

IV ACCESS

☐Yes ☐No IV
☐Yes ☐No Hep. Lock
☐Yes ☐No Subcutaneous Access Device
☐Yes ☐No PICC Line

COMMUNICATION ABILITY

☐Yes ☐No Can Speak
☐Yes ☐No Can Write
☐Yes ☐No Understands Speaking
☐Yes ☐No Understands Writing
☐Yes ☐No Communicates by Writing
☐Yes ☐No Understands Gestures
☐Yes ☐No Communicates by Gestures
☐Yes ☐No Understands English
If no, language spoken ____________________

GI/GU/NUTRITION

☐Yes ☐No TPN
☐Yes ☐No Tube Type ____________________
☐Yes ☐No Foley Inserted ____________________
☐Yes ☐No Ostomy
☐Yes ☐No Diarrhea
☐Yes ☐No Recent Weight Loss
☐Yes ☐No Diet Supplement
☐Yes ☐No Bowel Movement Date ________
Weight ____________________________________
Diet ____________________________________
____

IMMUNIZATIONS PROVIDED

☐Flu Date ______________
☐Pneumoccous Date ________________
☐Mantoux Date ____________________
Results __________________
☐Tetanus Date ____________________

INFECTION PROCESS

☐Yes ☐No Precautions Type _____________
☐Yes ☐No C Diff.
☐Yes ☐No VRE
☐Yes ☐No MRSA
☐Yes ☐No Drainage
☐Yes ☐No Shingles
☐Yes ☐No R/O TB
Other ____________________________________

RESPIRATORY STATUS

☐Yes ☐No Labored
☐Yes ☐No Unlabored
☐Yes ☐No Oxygen ________(rate)
☐Yes ☐No Pulse Oximetry ______%
☐Yes ☐No Trach
☐Yes ☐No Chest Tube
☐Yes ☐No Suctioning

PROSTHETIC DEVICES

☐Yes ☐No Eyeglasses
☐Yes ☐No Dentures
☐Yes ☐No Hearing Aid
Other ____________________________________
____
Therapy Orders ____________________________
____

MENTAL

☐Yes ☐No Alert
☐Yes ☐No Oriented
☐Yes ☐No Confused
☐Yes ☐No Noisy
☐Yes ☐No Combative
☐Yes ☐No Substance Abuse History
☐Yes ☐No Psych History
Dx ____________________________________

COMPLEX

☐Yes ☐No Dialysis
☐Yes ☐No Ventilator/Respirator

SKIN

☐Yes ☐No Rash
☐Yes ☐No Cellulitis
☐Yes ☐No Surgical Wound
☐Yes ☐No Drainage
☐Yes ☐No Pressure Ulcer
☐Yes ☐No Wound

NEURO/MUSCULAR

☐Yes ☐No Weightbearing
☐Yes ☐No Contracted _____(degree)
☐Yes ☐No Quadriplegic
☐Yes ☐No Paraplegic
☐Yes ☐No Left Side Weakness
☐Yes ☐No Right Side Weakness
☐Yes ☐No Seizure Precautions
☐Yes ☐No Amputee ____________

Social Information (adjustment to disability, emotional support from family, motivation for self care, financial plan) PAS Status

ADL's

Hearing	☐Normal	☐ Impaired	☐ Deaf	
Sight	☐Normal	☐ Impaired	☐ Blind	
Feeding	☐Independent	☐ Help w/ Feeding	☐ Cannot Feed Self	
Dressing	☐Independent	☐ Help w/ Dressing	☐ Cannot Dress Self	
Elimination	☐Independent	☐ Help To Bathroom	☐ Bedpan/Urinal Required	☐ Incontinent
Bathing	☐Independent	☐ Bathing w/ Help	☐ Bed Bath w/ Help	☐ Bed Bath
Ambulation	☐Independent	☐ Walk w/Assistance	☐Help To/From Chair	☐Bed Bound

Assistive Devices ____
Advance Directives ☐Yes ☐No
If Yes, Sent With Patient ☐Yes ☐No
COMMENTS: ____

WOUND CARE		
Location	Stage	Treatment

Medication at Time of Discharge	
Name of Medication & Dose	Time Last Given
Does Patient Need Narcotics? ☐Yes ☐No	

Attending Physician ________________________ Phone _____________
Consulting Physician ________________________ Phone _____________
Will this physician continue to care for patient after transfer? ☐Yes ☐No

Please attach: face sheet, latest therapy notes, all lab work, H&P, consults, progress notes, medical record, nutrition and SS evaluation and diagnostic tests.

RN Completing Form ____________________________________
Signature ____________________________________
Phone # ____________________________________