# RESIDENT TRANSFER FORM

INTERACT II
Interventions to Reduce Acute Care Transfers

**SENT TO:** *(Name of Hospital)*

**SENT FROM:** *(Name of Nursing Home)*

Date:___/___/_____ Unit: _____

**RESIDENT:**
*Last Name* *First Name* *MI*

DOB:____/____/_____
Language: ☐ English ☐ Other:_____
Resident is: ☐ SNF/rehab ☐ Long-term

**CONTACT PERSON:**
*(Relative, guardian or DPOA/Relationship)*

*name*

Is this the health care proxy? ☐ Yes ☐ No
Telephone:( ) _____ - _____
Notified of transfer: ☐ Yes ☐ No
Aware of diagnosis: ☐ Yes ☐ No

**CODE STATUS:**
☐ DNR ☐ DNH ☐ DNI ☐ Full Code

**MD/NP/PA IN NURSING HOME:**
☐ MD ☐ NP ☐ PA

*name*

Telephone:( )___-_____ Pager:( )___-_____

**WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?**

*name* *title* Telephone:( ) ____-_____

**REASON FOR TRANSFER** *(i.e., What Happened?)*

List of Diagnoses:_____

VS: BP____ HR____ RR____ T____ pOx____ FS glucose ____ Time Taken: ____:____ AM/PM
Allergies:_____ Tetanus Booster *(date)*:____/____/_____

Usual Mental Status:
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not alert

Usual Functional Status:
☐ Ambulates independently
☐ Ambulates with assistance
☐ Ambulates with assistive device
☐ Not ambulatory

***Please see SBAR form for additional information***

**DEVICES / SPECIAL TREATMENTS:**
☐ IV/PICC line
☐ Pacemaker
☐ Foley Catheter
☐ Internal Defibrillator
☐ TPN
☐ Other: _____

**AT RISK ALERTS:**
☐ None
☐ Falls
☐ Pressure Ulcer
☐ Aspiration
☐ Wanderer
☐ Elopement
☐ Seizure
☐ Harm to: ☐ Self ☐ Others
☐ Restraints
☐ Limited/non-weight bearing: ☐ Left ☐ Right
☐ Other: _____

**ISOLATION / PRECAUTION:**
☐ MRSA ☐ VRE
☐ C-Diff
☐ Other: _____
Site: _____
Comment: _____

**CAPABILITIES OF THE NURSING HOME TO CARE FOR THIS RESIDENT:**
☐ IVF therapy ☐ IV antibiotics ☐ MD/NP/PA follow up visit within 24 hours
☐ Q shift monitoring by an RN ☐ Other: _____

**NURSING HOME WOULD BE ABLE TO ACCEPT RESIDENT BACK UNDER THE FOLLOWING CONDITIONS:**
☐ ED determines diagnosis, and treatment can be done in NH
☐ Other: _____
☐ VS stabilized and follow up plan can be done in NH

Form Completed By:
*name* *title* *signature*

Report Called In By: Report Called To:
*name* *title* *name* *title*

# RESIDENT TRANSFER FORM

## ADDITIONAL INFORMATION

(may be faxed to ED/hospital within 7-12 hours)

INTERACT II
Interventions to Reduce Acute Care Transfers

**RESIDENT NAME:**

*Last*: _____ *First*: _____ *MI*: ____ *DOB*: ____/____/_____

Date Transferred to the Hospital: ____/____/_____

**TREATMENTS AND FREQUENCY:**

*(include special treatments such as dialysis, chemo-therapy, transfusions, radiation, TPN, hospice)*

**SKIN / WOUND CARE:**

High risk for pressure ulcer: ☐ Yes ☐ No

Pressure ulcers:
*(stage, location, appearance, treatments)*

Wound care sheet attached: ☐ Yes ☐ No

**IMMUNIZATIONS:**

Influenza Date: ____/____/_____

Pneumococcal Date: ____/____/_____

Tetanus Tet-Diphtheria Date: ____/____/_____

**DIET:**

Needs assistance with feeding: ☐ Yes ☐ No

Trouble swallowing: ☐ Yes ☐ No

Special consistency: *(thickened liquids, crush meds, etc.)*

Tube feeding: ☐ Yes ☐ No

**PHYSICAL THERAPY**

Resident is receiving therapy with goal of returning home: ☐ Yes ☐ No

*- or -*

Patient is LTC placement: ☐ Yes ☐ No

Weight bearing status:

☐ Non-weight ☐ Partial weight ☐ Full weight

Fall risk: ☐ Yes ☐ No

Interventions: _____

**ADLs:**

*(mark I=independent; D=dependent; A=needs assistance)*

_____ Bathing
_____ Dressing
_____ Toileting/Transfers
_____ Ambulation
_____ Eating
_____ Can ambulate _____ (distance) with _____ (assistive device or I)

**DISABILITIES:**

*(amputation, paralysis, contractures)*

**IMPAIRMENTS:**

*(cognitive, speech, hearing, vision, sensation)*

**CONTINENCE:**

☐ Bowel ☐ Bladder

Last bowel movement:
Date: ____/____/_____

**BEHAVIORAL or SOCIAL ISSUES and INTERVENTIONS:**

**FAMILY ISSUES:**

**PAIN ASSESSMENT:**

**SOCIAL WORKER:**

*name*

Telephone:( )_____ - _____

**REASON FOR ORIGINAL SNF ADMISSION:**

Bed hold: ☐ Yes ☐ No