Regional Nursing Home Transfer Form

DATE:_____ **TIME**: _____ **TRANSFERRING FACILITY**: _____
NURSING UNIT:_____ PHONE :_____ EXT:_____ CONTACT NURSE:_____
TRANSFERRED TO:_____ HOSPITAL CONTACT: _____

PATIENT'S NAME: _____ **DOB**: _____ **GENDER**: ____
SS#____-___-____ MEDICARE # _____ MEDICAID #_____ INSURANCE:_____
Religion: _____ DNR: _____ Living Will/Health Proxy:_____ Attached DNR/LW: ___
Responsible/Proxy: _____ Relation:_____ Phone: _____Notified: ___
NH Physician:_____ Preferred Admit Physician:_____ Contact Phone: _____

REASON FOR TRANSFER:_____
_____
MEDICAL HISTORY: _____
_____
_____
SURGICAL HISTORY:_____
_____
LAST HOSPITALIZATION DATE/DIAGNOSIS:_____
_____
ALLERGIES: _____
MEDICATIONS:_____
_____ □ATTACHED
INFECTIOUS DISEASE HISTORY: TB □ MRSA □ VRE □ OTHER □
EXPLAIN: _____
_____
CURRENTLY ON ISOLATION: Y___ N___ TYPE: _____

VITAL SIGNS PRIOR TO TRANSFER: BP_____ HR_____ RR_____ TEMP_____ O2 SAT_____

PATIENT'S PROFILE

CATEGORY	INDEP	PARTIAL	COMPLETE
EATING			
WALKING			
TRANSFER			
BATHING			
DRESSING			
TOILET			

BASELINE MENTAL STATUS
___Alert __Confused Mod
___Agitated __Confused Tot
___Assaultive __Unresponsive

Special Considerations: _____
_____
_____

DECUBITUS: Y___N___ LOCATION:_____
RX: _____
CONTRACTURES: Y __ N __ RESTRAINTS:Y__ N__
TYPE:_____

SPEECH: Normal ____ Impaired____ Aphasic _____
HEARING: Normal ____ Impaired ____ Deaf _____
Hearing Aids: Y ____ N ___ With Pt: Y __ N __
SIGHT: Normal ____ Impaired _____ Blind _____
Glasses: Y___ N ___ With Pt: Y____ N ____
APPLIANCES: Sling/splint Cane Walker
Prosthesis Dentures NG Tube G Tube
Foley Pacemaker Portacath Permanent IV
Other:_____
Ventilator:____ Settings:_____

Requested Studies or Procedures: _____
_____
_____REMO Nurses' Committee 2006