

# HOSPITAL TO NURSING FACILITY TRANSFER FORM

Name \_\_\_\_\_ Date & Time of Transfer \_\_\_\_\_

Transfer To: \_\_\_\_\_ Physician (s): \_\_\_\_\_

Transfer From: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Allergies: \_\_\_\_\_

Insurance: \_\_\_\_\_ Private \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ VA

## CHECKLIST

Completed Transfer Form  Telephoned report to nursing facility (person receiving report): \_\_\_\_\_  
 New Resident  Copies of reports (H&P, Discharge Summary, etc.)  Hearing Aid Returned  
 Completed 90L & PASARR  Living Will  DNR status  Durable Power of Attorney  Dentures Returned  
 Chest x-ray  PPD  Current lab or x-ray  Glasses Returned  
 Change in level of care  No Devices Returned

## SUMMARY OF CARE ISSUES ADDRESSED:

Oral Care  Medication  Family Situations  Diabetic Instruction  Disease/Medical History  
 Wound Care  Nutrition  Cognitive/Learning  Pain Control  Mobility  
 Elimination Needs  Self Care Needs  Respiratory Issues  Financial issues  Infection Control Issues

## PROGRESS TOWARDS GOALS:

Verbalizes understanding of:  
 Medications  Nutrition  Pain Control  Disease Process  
 Equipment use  Mobility  Self Transfers  Alteration in Life Style

## CONDITION AT DISCHARGE (TO BE COMPLETED BY NURSE):

**MUST BE COMPLETED** **CHECK ALL THAT APPLY**  
 Ambulating  Date of Last BM \_\_\_\_\_  Diet \_\_\_\_\_  Appetite:  Good  Fair  Poor  
 Bed Bound  Indwelling catheter:  Yes/Date changed: \_\_\_\_\_  Swallowing Difficulty:  Yes  No  
 Up in chair freq. \_\_\_\_\_  MRSA (check one):  colonization  Infection  Treatment: \_\_\_\_\_  
 Ambulating with assist  Hepatitis:  A  B  C  N/A  Mental Status (check one):  Confused  Alert  
Prosthesis Type: \_\_\_\_\_  
Weight bearing: (circle one):  Full  Partial  None

## IMMUNIZATIONS GIVEN:

Pneumococcal Vaccine \_\_\_\_\_ Date \_\_\_\_\_  Influenza Vaccine \_\_\_\_\_ Date \_\_\_\_\_

Vital Signs: \_\_\_\_\_ AM/PM P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ O/R

Pain (0-10): \_\_\_\_\_ Pain Character: \_\_\_\_\_

## SKIN/TISSUE STATUS:

Decubitus: \_\_\_\_\_ Yes \_\_\_\_\_ No  
1. Location \_\_\_\_\_ Date acquired \_\_\_\_\_ Stage \_\_\_\_\_ Description \_\_\_\_\_  
2. Location \_\_\_\_\_ Date acquired \_\_\_\_\_ Stage \_\_\_\_\_ Description \_\_\_\_\_  
3. Location \_\_\_\_\_ Date acquired \_\_\_\_\_ Stage \_\_\_\_\_ Description \_\_\_\_\_  
4. Location \_\_\_\_\_ Date acquired \_\_\_\_\_ Stage \_\_\_\_\_ Description \_\_\_\_\_  
 No skin breakdown  
 Surgical wound(s)  
 Skin Tear (s)

Nurse Completing Form: \_\_\_\_\_

## DISCHARGE INSTRUCTIONS AND ORDERS

Activity: \_\_\_\_\_ Diet: \_\_\_\_\_

Mode of transportation:  Private car  Wheelchair/Van  Stretcher  Other (specify) \_\_\_\_\_

Medication/Treatments: \_\_\_\_\_

Nurse Completing Form: \_\_\_\_\_



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