

## NURSING FACILITY TO HOSPITAL TRANSFER FORM

Name \_\_\_\_\_ Date & Time of Transfer \_\_\_\_\_  
LAST FIRST MIDDLE

Transfer To: \_\_\_\_\_ Attending MD: \_\_\_\_\_

Transfer From: \_\_\_\_\_ Consulting MD: \_\_\_\_\_

NH Contact Name: \_\_\_\_\_ Phone # with ext.: \_\_\_\_\_

Consulting Surgeon: \_\_\_\_\_ Allergies: \_\_\_\_\_

Pneumococcal Vaccine \_\_\_ N \_\_\_ Y \_\_\_\_\_ Date Influenza Vaccine \_\_\_ N \_\_\_ Y \_\_\_\_\_ Date

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

### CHECKLIST

|  |  |   |
|--|--|---|
| <input type="checkbox"/> Advanced Directives<br><input type="checkbox"/> DNR<br><input type="checkbox"/> Living Will<br><input type="checkbox"/> Durable Power of Attorney<br><input type="checkbox"/> Current Physician Orders<br><input type="checkbox"/> Accumulative Diagnosis Sheet | _____ Copies Sent<br><input type="checkbox"/> Current/Pertinent Lab or X-Rays<br><input type="checkbox"/> Completed Transfer Form<br><input type="checkbox"/> Responsible Party/Family Notified<br><input type="checkbox"/> Hearing Aid<br><input type="checkbox"/> Dentures Sent<br><input type="checkbox"/> Glasses Sent | Skilled Unit: ___ Y ___ N<br>If Yes: ___ Medicare ___ Medicaid<br><input type="checkbox"/> Bed Hold Policy ___ Copies<br><input type="checkbox"/> Admit Face Sheet<br>G or Peg Tube: _____<br>Trach: ___ Y ___ N _____ Size |
|--|--|---|

**At time of Transfer** (check all that apply): **Ambulatory** \_\_\_ **Confused** \_\_\_ **Alert** \_\_\_ **Lethargic** \_\_\_  
 Reason for Transfer/Add'l Info: \_\_\_\_\_

PRN Medications given prior to transfer: Med/Time \_\_\_\_\_

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

MRSA: \_\_\_ Y \_\_\_ N \_\_\_ History Hepatitis: \_\_\_ A \_\_\_ B \_\_\_ C

Colonization/Infection (circle one) Treatment: \_\_\_\_\_

#### MENTAL STATUS

Alert  
 Confused  
 Forgetful

#### DISABILITIES

Amputation  
 Paralysis (L,R, T)  
 Contracture

#### INCONTINENCE

Bladder  
 Bowel  
 Saliva

#### CATHETER

\_\_\_ Yes \_\_\_ No  
 Size: \_\_\_\_\_  
 Date Last Changed: \_\_\_\_\_  
 Date Last BM: \_\_\_\_\_

#### BEHAVIOR

Lethargic  
 Combative  
 Withdrawn  
 Noisy  
 Agitative

#### IMPAIRMENTS

Mentality  
 Speech  
 Hearing  
 Vision  
 Sensation

#### AMBULATORY

Independent  
 Walker \_\_\_ Bedfast  
 With Assistance

Cane  
 Crutches  
 Wheelchair

|                                |
|--------------------------------|
| Height: _____<br>Weight: _____ |
|--------------------------------|

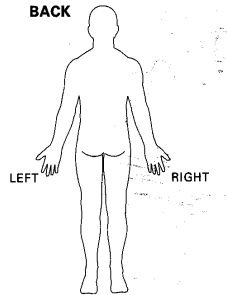
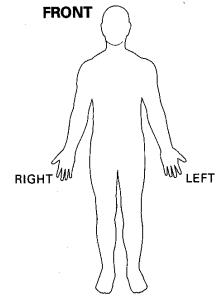
#### Activities of Daily Living:

Feeding

I=Independent  
 Grooming

A=Assist D=Dependent

Bathing \_\_\_ Toileting \_\_\_ Dressing \_\_\_\_\_ Other



#### SKIN/TISSUE STATUS:

Good (Well Nourished)  
 Fair (Poorly Nourished/Skin Intact)  
 Poor (Skin Not Intact)

Decubitus: \_\_\_\_\_ Yes \_\_\_\_\_ No

Location: \_\_\_\_\_

**Circle location with pressure ulcer stage on graph**

**PATIENT IS AT RISK FOR PRESSURE ULCERS: \_\_\_ Y \_\_\_ N**

**If yes, list Risk Factors:** \_\_\_\_\_



Nurse's Signature: \_\_\_\_\_  
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