

PATIENT NAME: LAST			FIRST:			MI	DOB
ADDRESS: Street		Apt.#	City:	State:	Zip:	Phone:	Social Security #:
MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Domestic Partner			RELIGION: <input type="checkbox"/> Catholic <input type="checkbox"/> Jewish <input type="checkbox"/> Hindu <input type="checkbox"/> Protestant <input type="checkbox"/> Muslim <input type="checkbox"/> Other:				
PAYOR: <input type="checkbox"/> See attached	<input type="checkbox"/> Medicare # <input type="checkbox"/> None			<input type="checkbox"/> Medicaid # <input type="checkbox"/> PAS Exempt: Medicaid pre-admission screening NOT done. Expected length and skilled nursing facility stay 20 days or fewer.		<input type="checkbox"/> None <input type="checkbox"/> Pending	
	HEALTH INSURANCE <input type="checkbox"/> None Company Name:			Policy #		Phone:	
MEDICAL REPORTS, VALUES, PROCEDURES: (related to reasons for transfer)		STUDY RESULTS: (x-ray, EKG, CT, MRI, Scan, etc.) <input type="checkbox"/> None <input type="checkbox"/> See attached					
		LAB VALUES: <input type="checkbox"/> None <input type="checkbox"/> See attached:			SURGICAL PROCEDURES: <input type="checkbox"/> None <input type="checkbox"/> See attached		
Comments:							

IMMUNIZATION STATUS: <input type="checkbox"/> See attached history	T.S.T. (PPD)	Date:	<input type="checkbox"/> Unknown	Hepatitis A	Date:	<input type="checkbox"/> Unknown
	Influenza	Date:	<input type="checkbox"/> Unknown	Hepatitis B	Date:	<input type="checkbox"/> Unknown
	Pneumococcal	Date:	<input type="checkbox"/> Unknown	Measles, Mumps, Rubella	Date:	<input type="checkbox"/> Unknown
	Meningococcal	Date:	<input type="checkbox"/> Unknown	Varicela	Date:	<input type="checkbox"/> Unknown
	D.T. P.	Date:	<input type="checkbox"/> Unknown	Inactivated Poliovirus	Date:	<input type="checkbox"/> Unknown

RESPIRATORY:	Delivery Device: <input type="checkbox"/> Mask <input type="checkbox"/> Cannula <input type="checkbox"/> CPAP <input type="checkbox"/> BPAP <input type="checkbox"/> Nebulizer <input type="checkbox"/> Other:						
<input type="checkbox"/> Oxygen:	Liters:	%	<input type="checkbox"/> Suction	<input type="checkbox"/> Trach size:	Type:	<input type="checkbox"/> Ventilator Settings:	
BOWEL:	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Ostomy <input type="checkbox"/> Appliance (type):				Comments:		
BLADDER:	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Urostomy <input type="checkbox"/> Appliance (type):				Comments:		
<input type="checkbox"/> Self Cath <input type="checkbox"/> Catheter (type):		Date last changed:			Comments:		
NUTRITION/ HYDRATION:	DIETARY INSTRUCTIONS:			TUBE FEEDING (Type):		<input type="checkbox"/> TPN	
	SUPPLEMENTS (type):		EATING: <input type="checkbox"/> Self <input type="checkbox"/> Assistance <input type="checkbox"/> Other:			PEG (length):	
IV ACCESS:	<input type="checkbox"/> PICC	Size:	Length:	#of Lumens:	<input type="checkbox"/> Heparin Lock:	<input type="checkbox"/> Port-A-Catheter:	

SKIN CARE/ ASSESSMENT:	<input type="checkbox"/> No wounds <input type="checkbox"/> TAR attached <input type="checkbox"/> See attached	Preventive Devices/Measures/Comments:					
WOUND SITE AND TYPE	STAGE / SIZE	CHARACTERISTICS		TREATMENT PLAN	RECENT STATUS		
Site: _____ <input type="checkbox"/> Tear <input type="checkbox"/> Trauma <input type="checkbox"/> Surgical <input type="checkbox"/> Vascular <input type="checkbox"/> Diabetic <input type="checkbox"/> Pressure related	1 2 3 4 US	Odor: <input type="checkbox"/> Yes <input type="checkbox"/> No Drainage: <input type="checkbox"/> Yes <input type="checkbox"/> No Tunneling: <input type="checkbox"/> Yes <input type="checkbox"/> No Wound Color: _____				Date of on-set ____/____/____ <input type="checkbox"/> improving <input type="checkbox"/> unchanged <input type="checkbox"/> worsening	
	L W D						
	L W D						
Site: _____ <input type="checkbox"/> Tear <input type="checkbox"/> Trauma <input type="checkbox"/> Surgical <input type="checkbox"/> Vascular <input type="checkbox"/> Diabetic <input type="checkbox"/> Pressure related	1 2 3 4 US	Odor: <input type="checkbox"/> Yes <input type="checkbox"/> No Drainage: <input type="checkbox"/> Yes <input type="checkbox"/> No Tunneling: <input type="checkbox"/> Yes <input type="checkbox"/> No Wound Color: _____				Date of on-set ____/____/____ <input type="checkbox"/> improving <input type="checkbox"/> unchanged <input type="checkbox"/> worsening	
	L W D						
	L W D						

PHYSICAL FUNCTIONS:	Recent Changes: <input type="checkbox"/> None <input type="checkbox"/> Yes, explain:						
<input type="checkbox"/> Bed Rest <input type="checkbox"/> Bed / Chair <input type="checkbox"/> Ambulation: <input type="checkbox"/> Alone <input type="checkbox"/> Attendant <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Other:							
<input type="checkbox"/> Wheelchair (type):				<input type="checkbox"/> Transfer: <input type="checkbox"/> Self <input type="checkbox"/> Assistance <input type="checkbox"/> 1 assistant <input type="checkbox"/> 2 assistants			
<input type="checkbox"/> Appliances:			<input type="checkbox"/> Prosthesis:		<input type="checkbox"/> Lifting Device:		
Weight Bearing: LEFT: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None				RIGHT: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None			
THERAPY:	<input type="checkbox"/> PT:		<input type="checkbox"/> OT:		<input type="checkbox"/> SPEECH:		
RESTRAINT:	Types:			Reasons for use:			
PERSONAL ITEMS:							

AUTHORIZATION <input type="checkbox"/> CHECK IF EMERGENCY TRANSFER (Complete all of page 1 and page 2 if time allows)					
Contents Prepared and Completed By:	Name:	Title:	Date:	Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Signature:	Unit:	Phone:		

Top (white) copy goes with patient/resident upon transfer. Middle (yellow) copy keep with sending facility patient/resident records.
Bottom (Pink) copy for research pilot program.