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