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Emergency Transfers of the Elderly from Nursing Facilities to Critical Access Hospitals: Opportunities for Improving Patient Safety and Quality

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Purpose of the Study

This Flex Monitoring Team study assesses the evidence base and best practices for improving the nursing facility-to-hospital transitions of care. Research has shown that essential information is often missing during transfer of nursing residents to the ED, and communication problems between nursing facilities and EDs are one of the most cited barriers to providing quality patient care. Tools, such as transfer forms and checklists, that improve communication between settings of care help improve patient safety and quality of care.

Approach

This Policy Brief reviews the literature on transfer of nursing facility residents to the hospital emergency department, with a focus on the transfer protocols as an indicator of patient safety. For the purpose of this study, transfers are defined as the one-way emergency trip from the NF via EMS to the hospital ED. Many of these transfers may result in admission or return to the NF, but the primary focus of this brief is on the initial transfer and the protocols that are in place to help improve patient safety. Based on responses to an email request sent to all State Flex Coordinators, follow-up interviews were conducted with selected Flex Coordinators, hospital or nursing facility administrators, and quality improvement organizations regarding transfer initiatives. These interviews and information gathered from the field provided the basis for the transfer protocol activities discussed later in the brief. The relevance to Critical Access Hospitals (CAHs) is discussed and examples of transfer protocols are provided.

Review of the Literature

Care transitions between and among nursing facilities and hospitals are a known risk factor for patient safety problems.[1-3] They are also a priority target for safety and quality improvement efforts to reduce preventable hospital readmissions and other adverse events and outcomes.[4-6] While there is a wealth of literature on discharge transfers from the hospital setting to nursing facilities, evidence-based literature on transfers from the nursing facility to the hospital is relatively scant.[4,7-10]

Key Findings

- **Transfers to the hospital emergency department (ED) are common for many nursing facility (NF) residents, with over 25% experiencing at least one ED visit annually, and many encountering repeat visits.**
- **Communication issues, including incomplete information during transfer, impact clinical care of the elderly NF resident transferred to the ED.**
- **Several studies strongly recommend the use of standardized transfer forms as a way of improving communication, which ultimately improves patient safety and quality of care. However, standardized transfer forms, in and of themselves, are not sufficient to solve communication issues between the sites of care (NF, EMS, ED).**
- **The establishment of ongoing relationships between hospital, EMS, and nursing facility staff help facilitate effective communication regarding patient needs during the transfer process and encourage the development of a systems approach to the transition of care.**

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Transfers to the ED are common for many nursing facility residents, with over 25 percent of nursing facility residents aged 65 years and older experiencing at least one ED visit annually, and many encountering repeat visits.[4,11-14] To put this in perspective, the total number of ED visits between 2000 and 2001 by residents of skilled nursing facilities was "twice as large as the actual number of skilled nursing home residents in the United States during the same time period."[14] Additionally, "transfer to the emergency department (ED) is a serious adverse event," according to Grunier et al.[15, p.203] Transitions of care are known to be a risk for older adults, particularly with comorbidities and complex conditions, as these patients are more susceptible to infection, error, or other complications.[15]

Transfers are costly for all parties (nursing facility, residents, and hospitals), not just in terms of dollars, but also the physical and emotional toll on patients and their families. The American Medical Directors Association's policy on transitions between NHs and hospitals states that the "first step in optimizing transfers [from the NF to the ED] is to avoid unnecessary transfers."[16, p.16] In the quest to improve patient safety and quality of care, understanding the factors that result in a decision to transfer can help identify the appropriate training and interventions that ultimately may help to reduce unnecessary transfers and admissions to the hospital. These factors are complex and involve both physiological and functional status of the resident along with psychosocial determinants, such as the presence of advance directives, family influences, nursing facility staffing and workload, and ease of access to medical or nursing care.[17-20]

Communication issues impact clinical care of the elderly resident transferred to the ED

Improving communication between the NF and the hospital ED helps to improve and ensure coordination and continuity of care for elderly residents, reducing unnecessary transfers and ultimately improving the quality of care.[16,21] Kelly and colleagues note that this population is at higher risk than most for medical errors related to lack of patient information and that detailed clinical information at transfer is important for patient safety and quality of care.[22] Patient transfer communication measures, developed and field-tested by researchers at the University of Minnesota for transfers from a hospital ED to a referral hospital or other facilities, address many of the same communication issues encountered in transfers from a nursing facility to the ED.[7] These measures have been adopted by the federal Office of Rural Health Policy as Phase 3 of the Flex Medicare Beneficiary Quality Improvement Project (MBQIP).

In a 1997 study of patient transfers from the NF to the ED, Jones and colleagues[17] evaluated the quality of the medical information sent with the patients, and found that 10% of patients arrived at the ED with no information from the nursing facility, and 90% had inconsistent communication of patient information; most were transported via ambulance services. The lack of communication between the nursing facility and the ED centered around the lack of advance directives, immunization information, baseline mental and functional status, and past medical history. The importance of these missing pieces of information is critical to the accurate and efficient assessment and treatment of the patient, with physicians rating nearly half of the information gaps as very important or essential to patient care.[23,24] Patients with an "information gap" were associated with 1.2 hours longer stay in the emergency department than patients without missing information.[23] Prolonged lengths of stay in the ED contribute to patient dissatisfaction and overcrowding and ultimately to decreased quality of patient care. Of particular concern is the finding from this study that most patients transferred from a nursing facility had significant information gaps, which raises questions about staffing, communication, and transfer protocols. Transfer forms are one way to minimize these gaps.

In Connecticut, a team of staff from six nursing facilities and three tertiary hospitals developed a communications process to combat this problem of missing information during transfer. This collaborative team, which formed to become a "Practice Improvement Cluster (PIC)", identified the areas of skin care, functional ability, and mental status as the key pieces of information needing to be included in any transfer documentation.[25] The PIC recognized the differing levels of technology and variety of forms at the various facilities, and developed a checklist to accompany the resident. The 22-item checklist becomes the top form in the transfer, indicating the documentation included in the transfer, such as reason for transfer, advance directives, contact persons (at the NF and family members), medications, mental status, and wound care. One of the realizations that emerged from this consensus-building effort was that "the quality of any patient transfer within the system was dependent on

the collaboration of the interdisciplinary team."[25, p.14] Consistent communication between sites was considered an essential element.

Handoffs from EMS to ED

In a recent review of the literature on handoffs of patients arriving by ambulance to the ED, Bost and colleagues found that differing styles of communication between the ambulance crews and the medical staff was a common theme in the quality and accuracy of the handoff.[26] According to one study, a lack of a shared understanding and common clinical language frustrated both sides, with one ED nurse describing the ambulance crews' language as "militaristic."[27] This lack of communication cuts both ways, however, with EMS and ambulance crews reporting that ED staff were attentive to the handoff report when the patient had clearly defined clinical care needs, but less attentive when the patients presented with ambiguous symptoms, indistinct medical diagnoses, or complex social problems.[28,29]

Recommendations for improving handoffs include using a standardized form along with training in the use and interpretation of the form by both ambulance and ED personnel.[26] Interestingly, only one study evaluated a structured format and standardized approach known by its acronym DeMIST (**De**mographics, **M**echanism of illness, **I**njuries, **S**igns/Symptoms, **T**reatment), and found, surprisingly, that it was not as successful as an unstructured format in the relaying verbal information by the ambulance crew or in the retention of it by the ED staff.[30] The authors suggested the reasons for its lack of success may have been because the form was unfamiliar to both sides and additional training and time were needed to make it useful. A pilot study of a new paramedic-to-ED handoff protocol also highlighted the need for familiarity and training on both sides in order for any standardized form to be accepted.[31] Additionally, direct involvement by EMS and ED staff in the development of the protocol contributed to the rapid acceptance and use of the form.

Transfer Forms

Several studies strongly recommend the use of standardized transfer forms as a way of improving communication, which ultimately improves patient safety and quality of care.[4,16,17,26,31-38] The assumed advantage of using such a form is that nursing facility staff, EMS providers, and ED staff would have the essential information in a concise format. The challenge to the use of a standardized form lies in the buy-in of all settings of care to agree to which are the essential pieces of information. This has been shown to be true in a study currently underway in Maine, with several of the NF, EMS, and CAH teams overcoming the "silo" approach to care to develop a transfer form that meets the needs of all settings.[39]

Over 20 years ago, a geriatric physician, concerned about the difference in approach and documentation between transfers from the hospital and transfers to the hospital for elderly patients, collaborated with the local nursing facilities in the Rochester, Minnesota area to develop a resident transfer form that would, in one page, provide the necessary clinical information for the hospital emergency staff and meet the documentation needs of nursing facility staff (See Appendix).[38] Similarly, a single page "Resident Transfer Form" was developed in 2005 in Texas through the collaborative efforts of an ED clinical nurse specialist and a geriatric clinical nurse specialist at the nursing facility (see Appendix), simple enough for NF staff to fill out in an emergency as well as providing the necessary clinical information for the ED staff when the resident arrives.[36,40]

Despite these successful examples of efforts to improve the transfer process, the following issues still continue to be raised in the literature: concerns about interfacility communication, lack of standardized transfer forms, and absence of essential pieces of information in the transfer.[32-35,41-46] State Flex programs can serve a role in funding quality improvement initiatives to address these issues.

What is being done to minimize these issues? Terrell and colleagues[34] developed a list of the 11 important elements needed in the transition from NF to ED for patient care: these included the resident's name, date of birth, and social security number, DNR status, contact information for the patient's primary care physician as well as the facility's name, phone number and name of the charge nurse, patient's usual mental and functional status, and the reason for transfer. In 2006, based on structured interviews/focus groups with ED nurses and physicians, additional elements considered essential for ED care were added. Many of these are typically included in a packet of information transferred with the resident: past medical history, medications, allergies, and most recent vital signs. However, the consensus of the focus groups indicated that inclusion of

the power of attorney or closest family member's contact number and the capabilities of the nursing facility (to give IV therapy, for example) were equally important.[35] An evaluation conducted in 2009 of the effectiveness of transfer forms utilizing these quality indicators proposed by Terrell showed that when transfer forms are used, information deemed essential and critical for the care of the patient in the ED had an increased chance of being transmitted.[47] Currently, Dr. Terrell and a cadre of co-investigators including Dr. Coleman, Director of the Care Transitions Program, are conducting a National Institutes of Health funded research project to validate the previously identified set of quality indicators for transfers between nursing facilities and emergency departments and to plan the formal testing of an intervention to improve the emergency care of nursing facility residents (http://medicine.iupui.edu/IUCAR/research/Terrell.aspx).

Both the Missouri Long-Term Care Best Practice Coalition and the Emergency Nurses Association have endorsed model forms and guidelines to provide standardized communication and transfer tools across the continuum of care from the nursing facility or long-term care site via EMS to the hospital ED.[48,49] Recognizing that each setting may have its own unique procedures, each organization provides a toolkit of forms that may be customized. The importance of their guidelines lies in the emphasis upon developing standardized communication processes, knowing that the use of such tools will ultimately improve the quality of care and patient safety.

Should there be a universal form applied across the nursing facility and hospital industry?

Given the evidence supporting the use transfer forms, would a statewide, standardized transfer form result in safer transfers and resolve the communication issues between sites of care? In a structured interview study in Indiana, Terrell and Miller, sought to indentify testable solutions (transfer forms, checklists, etc.) that would help improve the quality and safety of transfers between NHs and EDs.[9] One of the outcomes of this study was the recommendation by participants (which included NF administrators, nurses, EMS personnel, ED clinical staff, and a state Department of Health representative) that a statewide transfer form be made available.

In New Jersey, a state-mandated transfer form was developed over a three-year period by the Universal Transfer Form (UTF) Task Force, consisting of the collaborative efforts of New Jersey Hospital Association and the Health Care Association of New Jersey and health care professional from across the continuum of care (see Appendix). In August 2011, following extensive pilot testing and feedback, the New Jersey Department of Health and Human Services finalized the rules for the current 1,900 licensed health care providers and made the mandatory form and instructions available electronically. Training was provided by the Department prior to the final launch of the transfer form.[50] A formal evaluation of the form has not yet been conducted.

The American Medical Directors Association (AMDA) developed a three-page Universal Transfer Form designed to facilitate information transfer from one setting of care to another, flexible enough to be used when transferring residents either from the NF to the ED or back from the ED to the NF.[16] AMDA also recommends the use of the INTERACT II transfer tool (**INTE**rventions to **R**educe **A**cute **C**are **T**ransfers). INTERACT is part of a larger quality improvement initiative, initially funded by the Centers for Medicare and Medicaid Services (CMS) and now supported by the Commonwealth Fund, with the goal of reducing frequent and potentially unnecessary transfers to the hospital. Ten nursing facilities each in Massachusetts, New York, and Florida are part of the second phase of this initiative, and have demonstrated a significant reduction in acute care transfers.[51,52] The INTERACT II transfer form is to be completed for every NF resident transferred to the ED. According to the INTERACT website, consistent use of this tool will provide the essential information to the hospital ED staff to aid them in providing the most appropriate treatment. Additionally, it will insure a safe handoff of the NF resident to the ED (http://interact2.net). Most notably, this transfer form, which could be considered a "universal" form, is embedded in an educational context, with training guides and communication tools readily available. Thus, communication within the NF as well as externally via EMS and to the ED is an essential component of this transfer tool. Training on the INTERACT II form is also a component in several of the projects in the new joint Medicare-Medicaid Coordination Office and Center for Medicare and Medicaid Innovation initiative to reduce hospitalizations among nursing facility residents.[53] (For more information on this initiative, please go to the CMS website at: http://www.innovations.cms.gov/initiatives/rahnfr/index.html)

Translating the Evidence to Rural Communities and the Flex Program

Throughout the literature on transfer from nursing facilities to hospitals, handoffs, and transfer protocols, the emphasis is on collaboration and communication across settings of care. Although the issues are not rural-dependent, rural communities and CAHs are affected. As noted earlier, transfer to the ED from a nursing facility is a serious event, a time when these residents, especially those with complex needs, are susceptible to complication or error. The NF, EMS, and rural hospital ED can improve patient safety bythe streamlining and improveming communication across settings. State Flex Programs can play an important role in facilitating the development of collaborative relationships between NF, EMS, and CAH staff. The AMDA policy resolution on improving care transitions between the nursing facility and acute care hospital settings emphasizes the positive role that collaborative partnerships have in improving and measuring the quality of care.[16]

How Can State Flex Programs Help?

State Flex Programs can:

- improve the transfer process by funding quality improvement initiatives that collaboratively address issues to improve interfacility communication.
- support efforts to standardize transfer information by helping CAHs develop transfer checklists and forms that are grounded in the patient safety evidence-based literature.
- improve patient safety at the local, regional, and state level by working with and encouraging rural communities to collaborate on standardized transfer forms as part of a systems approach to care transition.

Following are selected examples of the use of standardized transfer forms and collaborative relationships in rural communities.

In **Maine**, the Maine Critical Access Hospital Patient Safety Collaborative, partially funded with State Flex dollars, is completing a two-year AHRQ-funded demonstration project with 10 CAHs to determine if improvement in information flow at time of transfer from the nursing facility via EMS to the CAH emergency department improves patient safety.[39] Each of the CAH pilot sites partnered with a local EMS service and a nearby nursing facility to collaborate on methods to improve the transfer process. Through their collaboration, new tools such as transfer forms, checklists, and traveling folders have been developed and shared amongst the Collaborative (See Appendix).

This study is assessing measures of improvement through chart reviews and qualitative interviews with pilot teams to assess improvements in the transfer process. Preliminary findings show that pilot sites demonstrated significant improvement in the documentation of essential pieces of patient information during the transfer process. Communication between the nursing facilities, EMS, and the CAH also improved significantly, with most of the pilot teams reporting a stronger collaboration between the three settings of care. One EMS provider noted that the development of the one-page transfer form not only has made the handoff from the nursing facility much more fluid (since they know what to look for on the form), but it has also helped them provide better care and improved the completeness of their report to the ED staff. The Collaborative provides a model for ways in which State Flex Programs can support a more effective delivery of services across local continuums of care.

In southeastern **New York**, a modified SBAR (Situation, Background, Assessment, Recommendation) form is used for transfers from the nursing facility to the CAH ED and back. (See Appendix). This form was developed through a collaborative effort between a regional medical center, a CAH and four primary nursing facilities in the CAH's service area. Approximately 90% of the time, the form accompanies the resident. A collaborative group consisting of the Administrator of Patient Care Services, the Chief Nursing Officers of the CAH and the regional medical center, any of the clinical directors from the hospital and nursing facilities, and EMS personnel meet quarterly, and all are in agreement that open communication across the settings is critical to the continued high rate of use of the SBAR form. Because of the open relationship between the organizations, ED staff are able to call staff from the nursing facilities and EMS and get an immediate response.

The Patient Care Services Administrator, who is also the Emergency Manager, noted that in addition to improved communication, the form has greatly increased quality of care, allowing the ED doctor and nurses to quickly scan the 1-page form for pertinent information needed to treat the patient quickly and

effectively. Despite the fact that a formal evaluation has not been conducted, staff report that the form has contributed to improvements in the transfer process. Training on the use of the form is provided on-site for staff. Each of the four nursing facilities have tweaked the form slightly for their purposes, such as adding a checkbox for inclusion of the MAR (Medication Administration Record), TAR (Treatment Administration Record), nurses notes or physicians notes. Each nursing facility includes on their form check boxes for Advanced Directives information and pneumococcal and influenza vaccine dates.

In **Virgini**a, a one-page "universal transfer form" was developed through the collaborative efforts of the Virginia Health Care Association (VHCA) and the Virginia Hospital and Healthcare Association (VHHA). The form provides for essential and critical pieces of information needed by the ED staff to treat the patient quickly. Stakeholders in the development process included a statewide taskforce consisting of the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Quality Center, the Virginia Department of Health, the Virginia Department of Social Services, attorneys, and representatives from nursing facilities, hospitals, home health agencies, and hospice organizations. The reverse side of the form is used by the ED to record and transmit treatment and contact information to the nursing facility upon return of the patient from the ED. Nine nursing facilities and six hospitals were involved in the pilot test of the form in 2008. Feedback led to slight modifications of the form that is available on the VHHA website (http://www.vhha.com/patienttransfer.html; See also Appendix). Unfortunately, due to competing initiatives, the form was not actively promoted by the Virginia Quality Improvement Organization (QIO), which some saw as a reason for its failure to gain widespread use (B. Soble, personal communication, February 17, 2012).

The QIO in **New Hampshire** is currently working on a transitions of care project, tracking transfer information across providers (hospitals, nursing facilities, and home health agencies) through the use of a tracking log. Although there are no CAHs currently involved in their study, the process is appropriate to facilities of all sizes including CAHs. Use of this tracking log has pointed out the need for additional and consistent communication across the continuum of care and highlighted the information missing from the transfer of the patient in the transitions.

Indiana's QIO recently completed a toolkit for their CAH Readmission project, using funds provided by the State Flex Program. This toolkit, available on CD, contains a wealth of information and tools for hospital performance improvement. While specifically geared to the topic of reducing hospital readmissions for heart failure and pneumonia, this toolkit contains a section on the use of the INTERACT II form described earlier. The importance of this toolkit lies in the collaborative and systems approach to improve communication between settings of care in order to improve patient outcomes.

In a frontier region of **Oregon**, a CAH and nursing facility share the same building, which would seem to facilitate the seamless transfer of information across the settings. However, despite sharing the same building, essential pieces of information are frequently missing during transfers from the nursing facility side to the CAH. This gap in the communication process has resulted in difficult situations involving the patient, the care manager, and the family. The administrator played a central role in convening collaborative meetings to help resolve these issues, and noted that, had there been a single-page form or checklist, some of the issues compromising appropriate treatment in a timely fashion could have been resolved.

In another example from **Oregon**, a co-located CAH and nursing facility demonstrate the effective use of transfer sheets to convey necessary clinical and patient information during the transfer process. The hospital has access to all NF records via its electronic medical record (EMR) system, and a nurse-to-nurse report usually accompanies each transfer. Staff shared between the ED and the nursing facility facilitates good communication between the settings of care.

Conclusion

The evidence base for use of standardized forms, checklists, and other communication tools during transfer between nursing facilities and hospital emergency departments suggests that these tools must meet the needs of the nursing facilities as well as the clinical needs of the hospital emergency departments. In addition, transfer forms and checklists facilitate the critical role of EMS in providing effective treatment of the nursing facility resident. In order to meet the needs of these providers across the continuum of care, collaboration is needed to identify key clinical information necessary to support the transfer process, develop a process and tool to share this information

between settings of care, and identify and address barriers to effective communications between these settings of care. The use of standardized transfer forms targets processes of care and as such, cuts across provider type and provides a consistent mechanism for cross-communication.[22] Standardized transfer forms, in and of themselves, are not sufficient to solve all communication issues during emergency transfers between nursing facilities and hospital EDs. The evidence shows that the development of collaborative relationships between staff at each setting of care is also needed to improve the transfer process. As one CAH administrator aptly stated, it's not the lack of a tool, but the implementation and interpretation that is the key. State Flex Programs can help improve patient safety at the local, regional, and state level by working with and encouraging rural communities to collaborate on standardized transfer forms as part of a systems approach to care transition.

Why Are Standardized Transfer Forms Helpful?

For Nursing Facilities: they help facilitate accurate exchange of information, reduce potentially avoidable hospitalizations, and provide a record of the patient's condition upon return.

For Nursing Facility residents: they help to increase the efficiency and effectiveness of transfer and treatment and may help the resident avoid additional health complications and emotional trauma.

For EMS: they provide the needed information to treat the patient en route and facilitate an accurate and comprehensive handoff report to the hospital.

For Hospitals: they help facilitate effective assessment and treatment of the patient in the ED, minimizes time spent in the ED, and reduces unnecessary admissions.

For Policymakers: to help reduce costs associated with unnecessary hospitalizations and longer ED lengths of stay.

Resources

Following the list of references, transfer forms from the following organizations are provided

American Medical Directors Association

Emergency Nurses Association

Greater Cincinnati Health Council

INTERACT II

Mayo Clinic

Maine CAH Patient Safety Collaborative

Missouri Long-Term Care Best Practice Coalition

New Jersey Universal Transfer Form

New York Catskill Regional Medical Center

Northeast Healthcare Foundation

Virginia Health Care Association

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Appendix: Sample Transfer Forms and Checklists

American Medical Directors Association (AMDA). *Universal Transfer Form,* revised 2012. http://
http://www.amda.com/tools/UTF%20revised%2012-2012.pdf

Emergency Nurses Association (ENA). *Safer Handoff : Patient Handoff Checklist* and
Patient Handoff/Transfer Form (NOTE: this is on 8 1/2 x 14 paper)

Greater Cincinnati Health Council. *Nursing Facility to Hospitals Transfer Form.*
http://www.gchc.org/wp-content/uploads/2011/06/Nursing-Facility-to-Hospital-Transfer-Form-Extended-Version-August-2011.pdf

INTERACT II. *Nursing Home to Hospital Transfer Form* and
Acute Care Transfer Document Checklist. Version 3.0.

Maine (Rumford Hospital). *Safe Passage Ticket* . Developed as part of the Maine Critical Access Hospital Patient Safety Collaborative.

Mayo Clinic. *Patient Transfer Form—Nursing Home to Hospital*
(Chutka, *Mayo Clinic Proceedings*, 1989)

Missouri. Making Caring Connections Best Practice Guidelines. *Long-Term Care Handoff Communications Form.*
http://health.mo.gov/seniors/bestpracticescoalition/pdf/ContinuityofCareTransferProject.pdf

New Jersey. *Universal Transfer Form.*
http://web.doh.state.nj.us/apps2/documents/ad/hcab_hfel7_0610.pdf

New York. Catskill Regional Medical Center. *SBAR Transfer Form*

Northeast Health Care Quality Foundation. *Transfer Checklist and Feedback*

Virginia. *Universal Model Transfer Form.*
http://www.gchc.org/wp-content/uploads/2011/06/Nursing-Facility-to-Hospital-Transfer-Form-Extended-Version-August-2011.pdf

American Medical Directors Association (AMDA). Universal Transfer Form, revised 2012.
http://www.amda.com/tools/UTF%20revised%2012-2012.pdf

Universal Transfer Form

AMDA has developed and recommends the use of the Universal Transfer Form (UTF) to facilitate the transfer of necessary patient information from one care setting to another. Patient transfers are fraught with the potential for errors stemming from the inaccurate or incomplete transfer of patient information. Use of the UTF can help to minimize the occurrence of such errors by ensuring that patient information is transmitted fully and in a timely fashion.

Patient's name: _____ Patient Identifier #2:_____
Setting Discharged from: _____
Setting Discharged to: _____
Attending physician in setting discharged from: _____
Admission date: / / Discharge date: / /

A. Admitting diagnosis: _____

B. Other diagnoses from this admission:
1._____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

C. Current diagnoses prior to admission:
1._____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

D. Surgical procedures and endoscopies during admission (include name of physician who performed the procedure) None ☐
1._____ Date/results _____ (may attach)
2. _____ Date/results _____ (may attach)
3. _____ Date/results _____ (may attach)

E. Laboratory values (please record most recent results, with date)

WBC	/ /	_____	BUN	/ /	_____
Hgb	/ /	_____	Creatinine	/ /	_____
Na+	/ /	_____	TSH/T4/T3	/ /	_____
K+	/ /	_____	Other	/ /	_____
Fasting glucose	/ /	_____			

F. Results and dates of pertinent studies (radiology, CT, MRI, nuclear scans, etc.) (may attach)
1. _____
2. _____
3. _____
Chest X-ray: Date performed:_____ Results: No active disease:_____
Or description if abnormal:_____

G. Allergies:
Medication: _____ Reaction:
Medication: _____ Reaction:
Foods: _____ Reaction:
Other: _____ Reaction:

H. Admission weight_____; Discharge weight:_____

I. Advance directives:

	Yes	No
CPR	☐	☐
PEG tube feeding	☐	☐
Further hospitalization	☐	☐

Other: _____
(Attach copies)

J. Has patient had a recent fall? Yes ☐ No☐ Is patient at risk for wandering? Yes ☐ No ☐

K. Comments on inpatient course: (may attach summary)

_____
_____
_____
_____
_____

L. Is the patient aware of his/her diagnosis(es)? Yes ☐ No ☐
If No, why not? _____

M. Patient's cognitive status for decision-making:
___ Independent ____Modified independence (some difficulty in new situations)
___ Moderately impaired (decisions poor) ___Severely impaired (never/rarely makes decisions)

N. Is the patient a candidate for rehabilitation therapy? Yes ☐ No ☐
If yes, state goals for rehabilitation:

_____
_____
_____

O. Discharge medication orders:

1._____ Rational: _____
Dose _____ Route _____ Frequency _____

2. _____ Rational: _____
Dose _____ Route _____ Frequency _____

3. _____ Rational: _____
Dose _____ Route _____ Frequency _____

4._____ Rational: _____
Dose _____ Route _____ Frequency _____

5. _____ Rational: _____
Dose _____ Route _____ Frequency _____

6. _____ Rational: _____
Dose _____ Route _____ Frequency _____

7._____ Rational: _____
Dose _____ Route _____ Frequency _____

8. _____ Rational: _____
Dose _____ Route _____ Frequency _____

9. _____ Rational: _____

Dose _____ Route _____ Frequency _____

10. _____ Rational: _____
Dose _____ Route _____ Frequency _____

P. Is patient currently on antibiotics? Yes ☐ No: ☐
Reason for antibiotic: _____
Antibiotic stop date: _____
Has patient been on antibiotics in last two weeks? Yes ☐ No: ☐
Does patient have a history of MDRO? Yes ☐ No: ☐
If yes, what type? _____
Has patient had a history of infectious diarrhea within the last 30 days? Yes ☐ No: ☐

Q. Diet: _____

R. Immunizations: Influenza: ____ Date PPD: ____ Results ____ Date ____
Pneumococcal: ____ Date TD : ____ Date +/_

S. Additional orders: _____
_____
_____
_____

T. Follow-up on consults/tests/procedures recommended: _____
_____
_____

U. Is patient legally competent? Yes ☐ No: ☐
If no, name of legally appointed decision-maker:
_____
If yes, but has a decision-maker, name of decision-maker:
_____

Name of physician /designee completing form:_____

Contact phone number: ( ) _____-_____ Extension or pager: _____

Date form completed: / /

Name of Primary Care Physician

Contact phone number: ( ) _____-_____ Extension or pager: _____

Emergency Nurses Association (ENA). ***Safer Handoff: Patient Handoff Checklist*** **and** ***Patient Handoff/Transfer Form***

(NOTE: print the Patient Handoff/Transfer Form on 8 1/2 x 14 paper)

Safer Handoff

PATIENT HANDOFF CHECKLIST

INSERT INSTITUTION LOGO

All Items **must travel with patients** at all times to and/or from LTC facility/agency and emergency department.

- *Place a check mark beside each item as information is compiled and ready to be sent with the patient.*
- *Mark N/A if not applicable.*

	1. **Completed** copy of the *Patient Handoff Form.*
	2. Copy of medical records
	3. Copy of Face Sheet
	4. Copy of all treatments (Treatment Authorization Request (TAR))
	5. Copy of recent physician's orders (Personal Order Sets (POS) or Computerized physician order entry (CPOE))
	6. Copy of recent lab results
	7. Copy of EKG results
	8. Copy of X-ray, CT Scan, MRI results
	9. Copy of surgical reports
	10. Copy of Discharge Summary
	11. Medication Administration Record (MAR) — *Dosage, frequency, route, date started, usual administration times, date and time of last dose given*
	12. Advanced directives
	13. Code Status – *Copy of signed DNR*
	14. Copy of follow-up appointments/continued care recommendations
	15. Small assistive devices (hearing aides, eyeglasses, dentures, etc) in fanny pack or envelope
	16. Most recent rehab summary (e.g., weight-bearing status, assistive devices)
	17. Pacemaker information (model number, etc. needed for recalls)
	18. Information on special treatments (e.g., radiation, dialysis, total parenteral nutrition)
	19. Reason for original LTC facility admission: Long-term or rehabilitation
	20. Bedhold status

SAMPLE

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Safer Handoff

PATIENT HANDOFF/ TRANSFER FORM

INSERT INSTITUTION LOGO

DATE OF TRANSFER: _____/_____/_____

TIME OF TRANSFER: _____ : _____ **AM** **PM**

PATIENT INFORMATION

_____
Last Name *First Name* *MI*

_____
Street Address *City*

_____
State/Province *Zip/Postal Code*

_____/_____/_____
DOB

SEX: M F

CONTACT PERSON/LEGAL GUARDIAN/DPOA

_____
Last Name *First Name*

( )
_____
Emergency Telephone

NOTIFIED *Yes* *No*

_____
Street, City, State/Province, Zip/Postal Code

_____
Relationship to Patient

NAME OF FACILITY TRANSFERRING FROM

_____
Facility Name *Address* *City* *State/Province* *Zip/Postal Code*

_____ ( )
_____
NAME OF RN/LPN/MD *in Charge of Patient at Time of Transfer* *Telephone*

REASON FOR TRANSFER

PRIMARY DIAGNOSIS

SECONDARY DIAGNOSIS

CODE STATUS

Copy of signed DNR Must Be Sent

DNR: ☐ Yes ☐ No **DNR Status**: ☐ CC ☐ CC Arrest **Full Code**: ☐ Yes ☐ No

ACUTE CHANGES FROM BASELINE ASSOCIATED WITH TRANSFER

VITAL SIGNS AT TRANSFER — TIME TAKEN: _____ : _____ AM PM

BP: / | TEMP: | PULSE: | RESP: | SaO_2: ☐ O_2 Therapy

IMMUNIZATION STATUS ☐ *Attached*

T.S.T. (PPD)	Date:	Results:	Hepatitis A:	Date:	☐ UNK
Influenza	Date:	☐ UNK	Hepatitis B:	Date:	☐ UNK
Pneumococcal	Date:	☐ UNK	Measles, Mumps, Rubella	Date:	☐ UNK
Meningococcal	Date:	☐ UNK	Varicella	Date:	☐ UNK
D.T.P.	Date:	☐ UNK	Inactivated Poliovirus	Date:	☐ UNK
Tetanus	Date:	☐ UNK			

TB Test	Date	Type	Result	***Biochem***	Date	Result	
Chest X-Ray	Date	Result		***Urinalysis***	Date	Result	
C.B.C.	Date	Result		***Fasting Glucose***	Date	Result	

ALLERGIES ☐ None ☐ UNK

Allergic To:	Reaction:	☐ UNK
Allergic To:	Reaction:	☐ UNK
Allergic To:	Reaction:	☐ UNK

ISOLATION/PRECAUTION

☐ None
☐ Contact
☐ Droplet
☐ Airborne

☐ MRSA	Date:	Site:
☐ VRE	Date:	Site:
☐ ESBL	Date:	Site:
☐ Other	Date:	
☐ *C*-Diff.	Date:	

SKIN/ WOUND CARE ☐ Intact ☐ Not Intact

Describe Decubitus/ Wound (Size, Site, Drainage):

MENTAL/COGNITIVE STATUS

Recent Changes (within last 7 days): ☐ None ☐ Yes, *explain:*

☐ Alert ☐ Confused ☐ Dementia ☐ Delirium ☐ Depressed ☐ Comatose ☐ Agitated

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Safer Handoff

PATIENT HANDOFF/ TRANSFER FORM

INSERT INSTITUTION LOGO

AT RISK ALERTS

- ☐ Fall
- ☐ Harm to Self
- ☐ Seizure
- ☐ Harm to Others (assaultive)
- ☐ Elopement
- ☐ Aspiration
- ☐ Impaired Safety Awareness
- ☐ Restraints
- ☐ Skin Failure (Breakdown) Braden Score:
- ☐ Other

TREATMENT RECEIVED WITHIN LAST 14 DAYS

- ☐ Chemotherapy
- ☐ Dialysis
- ☐ IV Medication
- ☐ Oxygen Therapy
- ☐ Transfusions
- ☐ Radiation Therapy
- ☐ Ventilator
- ☐ Tracheotomy Care
- ☐ Suctioning

IMPAIRMENT

- ☐ Mental
- ☐ Speech
- ☐ Hearing
- ☐ Vision
- ☐ Sensation

DISABILITIES

- ☐ Amputation
- ☐ Prosthesis
- ☐ Paralysis
- ☐ Paresis
- ☐ Contractures

SAFETY

- ☐ Restraints
- ☐ Sitter
- ☐ Wanders
- ☐ Siderails
- ☐ High Risk for Falls

INCONTINENCE

- ☐ Bladder
- ☐ Bowel
- ☐ Saliva

PATIENT USES

- ☐ Feeding Tube
- ☐ Foley Catheter
- ☐ Tracheotomy
- ☐ Central Line
- ☐ Ostomy
- ☐ Implant Defib
- ☐ Pacemaker

DECISION MAKING

- ☐ Independent
- ☐ Moderately Impaired
- ☐ Severely Impaired

ITEMS SENT WITH PATIENT *(Assistive Devices)*

- ☐ Glasses
- ☐ Hearing Aid
- ☐ Dentures
- ☐ Cane
- ☐ Crutches
- ☐ Walker
- ☐ Prosthesis: Left Right
- ☐ Other:

DIET

Type of Diet:	☐ Regular	☐ Mechanical Soft	☐ Thickened Liquid	☐ Other:
Diet Restrictions:	☐ Cardiac	☐ Renal	☐ Diabetic	☐ Other:
Feeding Requirement:	☐ Independent	☐ Needs Assistance	☐ Dependent	☐ Tube Feed

SPECIAL CARE ORDERS

- ☐ Enemas PRN
- ☐ O_2 - - - - - - - - - - - - - - - - Liter Flow: _____
- ☐ IV Care/PICC - - - - - - - - Date: / / Length: _____ Site: _____ Verified by X-ray: ☐ Yes ☐ No
- ☐ Wound Care/ Dressing Changes:
- ☐ Suction
- ☐ Respiratory Care
- ☐ Ventilator/Settings TV: _____ PEEP: _____ PCO_2: _____ SAO_2: _____ SIMV: _____
- ☐ Additional Orders *(Includes tubes, Foleys, IVs)*:

LAB WORK

THERAPIES

- ☐ PT
- ☐ OT
- ☐ ST
- ☐ RT

ATTACHMENTS

- **MEDICAL RECORDS** ☐
- **FACE SHEET** ☐
- **TAR** *(TREATMENTS)* ☐
- **POS** *(PHYSICIAN'S ORDERS)* ☐
- **RECENT LABS** ☐
- **EKGS** ☐
- **XRAYS/CT SCANS/MRIS** ☐
- **SURGICAL REPORTS** ☐
- **DISCHARGE SUMMARY** ☐

MEDICATION ADMINISTRATION RECORD (MAR) ☐ Yes ☐ No *Attach current medication list*

FOLLOW-UP APPOINTMENTS/ CONTINUED CARE RECOMMENDATIONS

☐ Yes ☐ No *Attach*

ADVANCED DIRECTIVES *Copy Must Be Sent*

- ☐ Living Will
- ☐ DPOA for Healthcare
- ☐ No transfusions
- ☐ Other

FORM COMPLETED BY: Name:_____ Title: _____ Signature: _____

REPORT CALLED IN BY: Name:_____ Title: _____

REPORT CALLED TO: Name:_____ Title: _____

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Greater Cincinnati Health Council. ***Nursing Facility to Hospitals Transfer Form.***

http://www.gchc.org/wp-content/uploads/2011/06/Nursing-Facility-to-Hospital-Transfer-Form-Extended-Version-August-2011.pdf

NURSING FACILITY TO HOSPITAL TRANSFER SHEET

GREATER CINCINNATI HEALTH COUNCIL

Date:	DOB:	
Resident's last name:	Resident's first name:	Middle:
Transferring facility:	Transferring facility phone:	
Receiving hospital:	Hospital Contacted? ☐ Yes ☐ No	
Destination: ☐ emergency department ☐ admitting ☐ outpatient ☐ clinic		
Resident's primary physician:	Has physician been notified? ☐ Yes ☐ No	
Family member's/guardian name:	Family member/guardian contacted? ☐ Yes ☐ No	
Phone number:	Work number:	Other number:

The following information *must* be attached: ☐ Medication sheet ☐ History and physical (H & P) ☐ Face sheet
(Attach documentation of last dose administered of medications)

Does patient have:		
Durable power of attorney?	☐ Yes ☐ No	Valuables with resident?
A living will?	☐ Yes ☐ No	Clean/Dry when leaving?
Orders to limit emergency treatment?	☐ Yes ☐ No	
A legal guardian?	☐ Yes ☐ No	
A Do Not Resuscitate Comfort Care?	☐ Yes ☐ No	
A DNRCC arrest?	☐ Yes ☐ No	

Please provide baseline documentation for each

ADLs: ☐ independent ☐ assisted ☐ dependent	
Vision: ☐ no identifiable problem ☐ blind ☐ contacts and/or ☐ glasses	Glasses with resident? ☐ Yes ☐ No
Hearing: ☐ within normal limits ☐ hard of hearing ☐ deaf ☐ hearing aid	Hearing aid with resident? ☐ Yes ☐ No
Mentation: ☐ alert oriented ☐ combative ☐ confused ☐ unresponsive	
Speech: ☐ within normal limits ☐ hard to understand ☐ aphasic ☐ equipment	
Feeding: ☐ independent ☐ assisted ☐ dependant ☐ dentures	Dentures with resident? ☐ Yes ☐ No
Diet: Need Assist:	
Allergies:	

Vitals and baseline:

Temp:	Pulse:	Resp:	BP:	Age:	Height:	Weight:
Time taken:		Pox:	O2:	Pain Level:	Location:	

Resistant organism? ☐ Yes ☐ No	If yes: ☐ MRSA ☐ C-Diff ☐ VRE ☐ other
Communicable disease? ☐ Yes ☐ No	If yes, describe?
Flu Vaccine? ☐ Yes ☐ No Date:	Pneumonia vaccine? ☐ Yes ☐ No Date:
Tetanus? ☐ Yes ☐ No Date:	Copy of immunization record attached? ☐ Yes ☐ No

Private ambulance preference for return transfer: _____ Phone: _____

Chief complaint/problem? _____

_____

Physician order(s): _____

_____

Nurse's Signature: _____ Most recent hospital stay within 90 days:

Print: _____

Date: _____ Time: _____

Phone: _____

INTERACT II. ***Nursing Home to Hospital Transfer Form*** **and** ***Acute Care Transfer Document Checklist.*** **Version 3.0, revised 2012.**

http://interact2.net/tools-v3.html

Nursing Home to Hospital Transfer Form

http://interact2.net/docs/INTERACT%20Version%203.0%20Tools/Communication%20Tools/Communication%20Between%20the%20Nursing%20Home%20and%20Hospital/INTERACT%20Nursing%20Home%20to%20Hospital%20Transfer%20Form%20Dec%2029%20Revised.pdf

Acute Care Transfer Document

http://interact2.net/docs/INTERACT%20Version%203.0%20Tools/Communication%20Tools/Communication%20Between%20the%20Nursing%20Home%20and%20Hospital/INTERACT%20Acute_Care_Transfer_Checklist_v7%20Jan%2019.pdf

Acute Care Transfer Document Checklist

INTERACT® Version 3.0 Tool

Resident Name _____

Facility Name _____ **Tel** _____

Copies of Documents Sent with Resident *(check all that apply)*

Documents Recommended to Accompany Resident

_____ Resident Transfer Form

_____ Face Sheet

_____ Current Medication List or Current MAR

_____ SBAR and/or other Change in Condition Progress Note *(if completed)*

_____ Advance Directives *(Durable Power of Attorney for Health Care, Living Will)*

_____ Advance Care Orders *(POLST, MOLST, POST, others)*

Send These Documents *if indicated*:

_____ Most Recent History and Physical

_____ Recent Hospital Discharge Summary

_____ Recent MD/NP/PA and Specialist Orders

_____ Flow Sheets *(e.g. diabetic, wound care)*

_____ Relevant Lab Results *(from the last 1-3 months)*

_____ Relevant X-Rays and other Diagnostic Test Results

_____ Nursing Home Capabilities Checklist *(if not already at hospital)*

Emergency Department:

Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

Amubulance Driver Signature *(optional)* _____

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Nursing Home to Hospital Transfer Form

INTERACT®
Version 3.0 Tool

Resident Name *(last, first, middle initial)* _____
Language: ☐ English ☐ Other _____ Resident is: ☐ SNF/rehab ☐ Long-term
Date Admitted *(most recent)* _____/_____/_____ DOB _____/_____/_____
Primary diagnosis(es) for admission _____

Sent To *(name of hospital)* _____
Date of transfer _____/_____/_____
Sent From *(name of nursing home)* _____ Unit _____

Contact Person _____
Relationship *(check all that apply)*
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (_____) _____
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

Who to Call at the Nursing Home to Get Questions Answered
Name / Title _____
Tel (_____) _____

Primary Care Clinician in Nursing Home ☐ MD ☐ NP ☐ PA
Name _____
Tel (_____) _____

Code Status ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain

Key Clinical Information
Reason(s) for transfer _____
Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____
Relevant diagnoses ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ Ca *(active treatment)* ☐ Dementia ☐ Other _____
Vital Signs BP _____ HR _____ RR _____ Temp _____ O2 Sat _____ Time taken *(am/pm)* _____
Most recent pain level _____ (☐ N/A) Pain location: _____
Most recent pain med _____ Date given _____/_____/_____ Time *(am/pm)* _____

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 assistive device
☐ Ambulates only with human assistance
☐ Not ambulatory

Additional Clinical Information:
☐ SBAR Acute Change in Condition Note included
☐ Other clinical notes included
For residents with lacerations or wounds:
Date of last tetanus vaccination *(if known)* _____/_____/_____

Devices and Treatments
☐ O2 at _____ L/min by ☐ Nasal canula ☐ Mask (☐ Chronic ☐ New)
☐ Nebulizer therapy; (☐ Chronic ☐ New)
☐ CPAP ☐ BiPAP ☐ Pacemaker ☐ IV ☐ PICC line
☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator
☐ Enteral Feeding ☐ TPN ☐ Other _____

Isolation Precautions
☐ MRSA ☐ VRE
Site _____
☐ C. difficile ☐ Norovirus
☐ Respiratory virus or flu
☐ Other _____

Allergies
_____
_____
_____
_____
_____

Risk Alerts
☐ Anticoagulation ☐ Falls ☐ Pressure ulcer(s) ☐ Aspiration ☐ Seizures
☐ Harm to self or others ☐ Restraints ☐ Limited/non-weight bearing: (☐ Left ☐ Right)
☐ May attempt to exit ☐ Swallowing precautions ☐ Needs meds crushed
☐ Other _____

Personal Belongings Sent with Resident
☐ Eyeglasses ☐ Hearing Aid
☐ Dental Appliance ☐ Jewelry
☐ Other _____
_____

Nursing Home Would be able to Accept Resident Back Under the Following Conditions
☐ ER determines diagnoses, and treatment can be done in NH ☐ VS stabilized and follow up plan can be done in NH
☐ Other _____

Additional Transfer Information on a Second Page:
☐ Included ☐ Will be sent later

Form Completed By *(name/title)* _____ **Signature** _____
Report Called in By *(name/title)* _____
Report Called in To *(name/title)* _____ Date _____/_____/_____ Time *(am/pm)* _____

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Nursing Home to Hospital Transfer Form *(additional information)*

INTERACT®
Version 3.0 Tool

Not critical for Emergency Room evaluation; may be forwarded later if unable to complete at time of transfer.
RECEIVER: PLEASE ENSURE THIS INFORMATION IS DELIVERED TO THE NURSE RESPONSIBLE FOR THIS PATIENT

Resident Name *(last, first, middle initial)* _____

DOB _____/_____/_____ Date transferred to hospital _____/_____/_____

Contact at Nursing Home for Further Information

Name / Title _____

Tel (_____) _____

Social Worker

Name _____

Tel (_____) _____

Family and Other Social Issues *(include what hospital staff needs to know about family concerns)* _____

Behavioral Issues and Interventions

Primary Goals of Care at Time of Transfer

☐ Rehabilitation and/or Medical Therapy with intent of returning home
☐ Chronic long-term care
☐ Palliative or end-of-life care
☐ Receiving hospice care ☐ Other _____

Treatments and Frequency *(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN)*

Diet

Needs assistance with feeding? ☐ No ☐ Yes
Trouble swallowing? ☐ No ☐ Yes
Special consistency *(thickened liquids, crush meds, etc…)?* ☐ No ☐ Yes

Enteral tube feeding? ☐ No ☐ Yes *(formula/rate)* _____

Skin/Wound Care

Pressure Ulcers *(stage, location, appearance, treatments)*

Immunizations

Influenza:
Date _____/_____/_____
Pneumococcal:
Date _____/_____/_____

Physical Rehabilitation Therapy

Resident is receiving therapy with goal of returning home? ☐ No ☐ Yes
Physical Therapy: ☐ No ☐ Yes
Interventions _____
Occupational Therapy: ☐ No ☐ Yes
Interventions _____
Speech Therapy: ☐ No ☐ Yes
Interventions _____

ADLs Mark I = Independent D = Dependent A = Needs Assistance

Bathing _____ Dressing _____ Transfers _____
Toileting _____ Eating _____

☐ Can ambulate independently _____
☐ Assistive device *(if applicable)* _____
☐ Needs human assistance to ambulate _____

Impairments – General

☐ Cognitive ☐ Speech ☐ Hearing
☐ Vision ☐ Sensation
☐ Other _____

Impairments – Musculoskeletal

☐ Amputation ☐ Paralysis ☐ Contractures
☐ Other _____

Continence

☐ Bowel ☐ Bladder
Date of last BM _____/_____/_____

Additional Relevant Information _____

Form Completed By *(name/title)* _____

If this page sent after initial transfer: Date sent _____/_____/_____ Time *(am/pm)* _____

Signature _____

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Maine (Rumford Hospital). ***Safe Passage Ticket***

Developed as part of the Maine Critical Access Hospital Patient Safety Collaborative.

Safe Passage Ticket [created by Rumford Hospital, Maine]

Name: _____
Date of Birth: ____/____/____
PCP: _____
Code Status: **DNR** **DNI**
(if DNR, attach a copy of the order)

Recent Vitals: P ____ R ____ B/P _____
BS _____ T_____ O2 sat _____
Recent Meds: _____
_____
Results: _____
_____

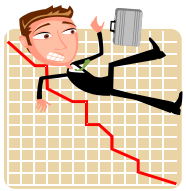
Level of Care
Secure Unit ☐
Skilled: ☐
Long Term: ☐
Res Care: ☐
ADS: ☐

Allergies
Meds: _____
_____
Foods: _____
_____
Other: _____
_____

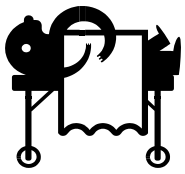
Oxygen Therapy
No ☐
Yes ☐
_____ liters per min.

Treatment
IV Meds: _____
_____
Enteral Feed: _____
_____

Fall Risk
No ☐
Yes ☐



Can resident be left alone?
No ☐
Yes ☐



Mental Status

Alert ☐

Disoriented ☐

Combative ☐

Other ☐
_____

Mobility

Ambulatory ☐

1 or 2 Assist ☐

Wheelchair ☐

Stretcher ☐

Hoyer Lift ☐

Communication

HOH/Deafness ☐

Vision/Blindness ☐

Language Barrier ☐

Primary Language: _____

Isolation/Infection
No ☐
Yes ☐

Contact ☐

Droplet ☐

Airborne ☐

CDiff: Hx ☐
Infection ☐

MRSA: Hx ☐ Infection ☐
Location: _____
VRE: Hx ☐ Infection ☐

Reason for transfer:

Comments:

☐ Med list/MAR included
☐ Pt. Demographic sheet attached
☐ DNR documentation
☐ Family notified
☐ Unable to reach family

Completed by: _____
Name Title

Report given to: _____
Name Title

Date: _____/_____/_____ Time: _____AM/PM

Mayo Clinic. ***Patient Transfer Form—Nursing Home to Hospital***

Source: Chutka DS, Freeman PI, Tangalos EG. Convenient Form for Transfer of Patients From Nursing Home to Hospital. ***Mayo Clin Proc*****. 1989; 64(10):1324-5.**

Patient Transfer Form -- Nursing Home To Hospital

Name _____ (Last / First / Middle) Mayo Clinic Number ___ - ___ ___ ___ - ___ ___ ___

Code Status/Critical Care Plan _____

Date of Birth _____ Physician _____

Sex ☐ Male ☐ Female Nursing Home _____

Religion _____ Phone _____

Relative/Guardian _____ Family notified of transfer ☐ Yes ☐ No

Phone _____

Social Security # _____ Medicare # _____ Medicaid # _____

Transferred to _____ Diet _____

Reason for transfer _____

Vital signs HR _____ Resp _____ Temp _____ BP ____ Allergies _____

Valuables accompanying patient _____

Medical Information

Diagnoses: _____

Medications - Dosage | Time Last Given

Usual Mental Status ☐ Alert ☐ Wanders ☐ Confused ☐ Oriented ☐ Combative ☐ Withdrawn

Nurse Signature _____ Date _____

PART 1 - SEND WITH PATIENT TO HOSPITAL

Nursing Information

ACTIVITIES OF DAILY LIVING

		COMMENTS
Ambulation	1. Independence w/wo assistive device 2. Walks with supervision 3. Walks with continuous physical support 4. Bed to chair (Total Help). 5. Bedfast	
Transfer	1. No assistance 2. Equipment only 3. Supervision only 4. Requires transfer w/wo equipment 5. Bedfast	
Bladder Control	1. Continent 2. Rarely e.g., h.s. 3. Occasional--once/week or less 4. Frequent--up to once a day 5. Total incontinence 6. Catheter--indwelling	
Bowel Control	1. Continent 2. Rarely 3. Frequent--once a week or more 4. Total incontinence 5. Ostomy	
Bathing	1. No assistance 2. Supervision only 3. Assistance in shower/tub 4. Is bathed in shower/tub 5. Is bathed--bed bath procedure	
Dressing	1. Dresses self 2. Minor assistance 3. Partial help, completes 1/2 dressing 4. Has to be dressed	
Feeding	1. No assistance 2. Minor assistance--needs tray set up only 3. Help in feeding/encouraging 4. Is fed	

SENSORY/LANGUAGE IMPAIRMENTS

		AID/PROSTHESIS
Sight	1. Good 2. Vision adequate--Unable to read fine print 3. Vision limited--Gross object differentiation 4. Blind	
Hearing	1. Good 2. Hearing slightly impaired 3. Limited hearing (e.g.--must speak loudly) 4. Virtually/completely deaf	
Speech	1. Speaks clearly with others of same language 2. Some defect--usually gets message across 3. Unable to speak clearly or not at all	

Fig. 1. Form used for transferring patients from nursing home to hospital.

Missouri. Making Caring Connections Best Practice Guidelines. *Long-Term Care Handoff Communications Form.*

http://health.mo.gov/seniors/bestpracticescoalition/pdf/ContinuityofCareTransferProject.pdf

LONG-TERM CARE HANDOFF COMMUNICATION

From ☐ SNF ☐ ICF ☐ RCF/ALF ☐ Swing Bed ☐ Rehab ☐ LTCH ☐ Group Home ☐ Other _____

LTC Center	Address
Phone	Fax
Resident's Physician ☐ Notified	Physician Phone

Resident Name (Last, First, MI)	Date of Birth	Sex	Social Security Number

Reason for Transfer ☐ Altered Mental Status ☐ Shortness of Breath ☐ Hyper/Hypoglycemia ☐ Fever ☐ Chest Pain ☐ Abdominal Pain ☐ Weakness ☐ Other _____ ☐ Injury/Fall (Describe) _____ Date/Time Onset/Injury _____

CODE STATUS ☐ See DNR Form ☐ Full ☐ Limited ☐ DNR

ALLERGIES ☐ No Known Allergies ☐ See MAR

☐ Durable Power of Attorney for Health Care ☐ Guardian
Name Phone

☐ Health Care Decision Maker or Local Contact Notified of Transfer
Name Phone

Advance Directives ☐ Yes ☐ No

Resident able to make own decisions ☐ Yes ☐ No

Speaks English ☐ Yes ☐ No If no, specify

Religious/Literacy Concerns ☐ None

Admissions to Hospitals/Other Facilities in Past Month ☐ None

Chronic Conditions ☐ See Diagnosis Sheet

Immunizations ☐None ☐Influenza____/____/____ ☐ Pneumonia ____/____/____ ☐ Tetanus____/____/___ ☐TB Skin Test____/____/

CHECK ALL THAT APPLY

Mental Status ☐ Alert ☐ Oriented ☐ Non-Verbal ☐ Unresponsive ☐ Confused ☐ Uncooperative ☐ Disruptive ☐ Withdrawn ☐ Depressed

Impairments ☐ Mental (describe)	☐ Speech (describe)	☐ Hearing (describe)	☐ Vision (describe)	☐ Sensation (describe)

Disabilities ☐ Amputation (describe)	☐ Prosthesis (describe)	☐ Contracture (describe)	☐ Paralysis (describe)

Mobility ☐No Mobility Aids ☐Cane ☐Walker ☐ W/C ☐ Bed Bound ☐ No Weight Bearing ☐ Partial Weight Bearing ____ Leg

Falls Last 30 Days ☐ No ☐Yes ___/___/___ ___/___/___ Injury ☐No ☐ Yes (describe)_____

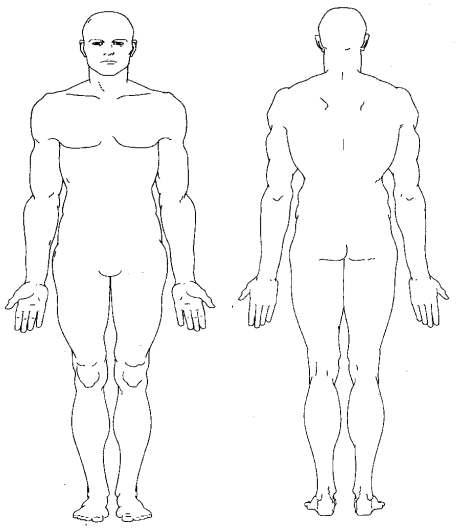
Infection ☐ MRSA Site ☐ VRE Site ☐ C. difficile ☐ UTI ☐ Other

Elimination Last BM____/____/____ Urinary Cath. In Past Month ☐ Yes ☐ No Inserted/Changed____/____/____ Discontinued____/____/____

Records Sent or Faxed ☐ Face Sheet ☐ H&P ☐ Medication Administration Record (Current) ☐ Physician Order Sheet (Most Recent) ☐ Last Nursing Assessment ☐ Current Lab & Radiology Report ☐ This Form ☐ Advance Directives/ DPOA ☐ DNR Form ☐ Diagnosis Sheet

Belongings Sent With Resident ☐ None ☐ Eyeglasses/Contacts ☐ Dentures/Partial Plates ☐ Upper ☐ Lower ☐ Both ☐ Hearing Aid(s) ☐ L ☐ R ☐ Cane ☐ Walker ☐ Splint ☐ Brace ☐ Wound Vac ☐ Jewelry (list)_____

Skin and Body Assessment ☐Skin Intact ☐Skin Not Intact—Identify each area with a number on the diagram and describe site & care in notes below.



#1 Site_____
Care_____
#2 Site_____
Care_____
#3 Site _____
Care_____

Transfer Date ____/____/____ Transfer Time _____

Facility Transferred To_____

Transported by ☐EMS ☐Family ☐ LTC Facility

Last Vital Signs TIME_____ BP _____ T _____ P _____ R _____ Pulse Ox _____

Current Height _____ Weight _____

Verbal Report Given by (print name/title) _____

Verbal Report Received by (print name/title)_____

Time Report Called _____

Signature and Title_____ Date____/____/____ Time_____

New Jersey Universal Transfer Form

http://web.doh.state.nj.us/apps2/documents/ad/hcab_hfel7_0610.pdf

NEW JERSEY UNIVERSAL TRANSFER FORM

(Items 1 – 28 must be completed)

1. TRANSFER FROM: _____
   TRANSFER TO: _____
2. DATE OF TRANSFER: _____
   TIME OF TRANSFER: _____ ☐AM/☐PM
3. PATIENT NAME: _____
   Last *First Name and Nickname* *MI*
   PATIENT DOB *(mm/dd/yyyy)*: _____ **SEX** ☐M ☐F
4. LANGUAGE: ☐ English ☐ Other: _____
5. PHYSICIAN NAME _____ PHONE _____
6. CODE STATUS: ☐ DNR ☐ DNH ☐ DNI
   ☐ Out of Hospital DNR Attached
7. CONTACT PERSON _____ RELATIONSHIP _____
   PHONE (Day) _____ (Night) _____ (Cell) _____
   Check if Contact Person:
   ☐ Health Care Representative/Proxy ☐ Legal Guardian
   NAME OF ☐ HEALTH CARE REPRESENTATIVE/PROXY
   OR ☐ LEGAL GUARDIAN, IF NOT CONTACT PERSON: _____
   PHONE (Day) _____ (Night) _____ (Cell) _____
8. REASONS FOR TRANSFER: *(Must include brief medical history and recent changes in physical function or cognition.)* _____

V/S: BP _____ P _____ R _____ T _____ PAIN: ☐None ☐Yes, Rating _____ Site _____ Treatment _____

9. PRIMARY DIAGNOSIS _____ ☐ Pacemaker
   Secondary Diagnosis _____ ☐ Internal Defib.
   Mental Health Diagnosis (if applicable) _____
10. RESTRAINTS: ☐No ☐Yes (describe) _____
11. RESPIRATORY NEEDS: ☐None ☐Oxygen-Device _____ Flow Rate _____
    ☐CPAP ☐BPAP ☐Trach ☐Vent ☐Related details attached ☐Other _____
12. ISOLATION/PRECAUTION: ☐None ☐MRSA ☐VRE ☐ESBL ☐C-Diff ☐ Other _____
    Site _____ Comments _____ ☐Colonized
13. ALLERGIES: ☐None ☐Yes, List _____
14. SENSORY: Vision ☐Good ☐Poor ☐Blind ☐Glasses
    Hearing ☐Good ☐Poor ☐Deaf Hearing Aid ☐Left ☐Right
    Speech ☐Clear ☐Difficult ☐Aphasia
15. SKIN CONDITION: ☐No Wounds
    ☐YES, Pressure, Surgical, Vascular, Diabetic, Other ☐*See Attached TAR*
    Type: ☐P ☐S ☐V ☐D ☐O
    Site _____ Size _____ Stage *(Pressure)* _____ Comment _____
    Type: ☐P ☐S ☐V ☐D ☐O
    Site _____ Size _____ Stage *(Pressure)* _____ Comment _____
16. DIET: ☐Regular ☐Special (describe): _____
    ☐Tube feed ☐Mechanically altered diet ☐Thicken liquids
17. IV ACCESS: ☐None ☐PICC ☐Saline lock ☐IVAD ☐AV Shunt ☐Other: _____
18. PERSONAL ITEMS SENT WITH PATIENT: ☐None ☐Glasses ☐Walker ☐Cane
    Hearing Aid: ☐Left ☐Right Dentures: ☐Upper/Partial ☐Lower/Partial ☐Other: _____
20. AT RISK ALERTS: ☐None
    ☐Falls ☐Pressure Ulcer ☐Aspiration
    ☐Wanders ☐Elopement ☐Seizure
    Harm to: ☐N/A ☐Self ☐Others
    Weight Bearing Status: ☐None
    Left Leg: ☐Limited ☐Full
    Right Leg: ☐Limited ☐Full
21. MENTAL STATUS:
    ☐Alert ☐Forgetful ☐Oriented
    ☐Unresponsive ☐Disoriented ☐Depressed
    ☐Other _____
22. FUNCTION:

	Self	With Help	Not Able
Walk	☐	☐	☐
Transfer	☐	☐	☐
Toilet	☐	☐	☐
Feed	☐	☐	☐

23. IMMUNIZATIONS/SCREENING:
    ☐Flu Date: _____ ☐Tetanus Date: _____
    ☐Pneumo Date: _____ ☐PPD **+/-** Date: _____
    ☐Other: _____ Date: _____
24. BOWEL: ☐Continent ☐Incontinent Date last BM _____
    Comments: _____
25. BLADDER: ☐Continent ☐Incontinent ☐Foley Catheter
    Comments: _____
19. ATTACHED DOCUMENTS: *MUST ATTACH CURRENT MEDICATION INFORMATION* ☐Face Sheet ☐MAR ☐Medication Reconciliation ☐TAR ☐POS ☐Diagnostic Studies
    ☐Labs ☐Operative Report ☐Respiratory Care ☐Advance Directive ☐Code Status ☐Discharge Summary ☐PT Note ☐OT Note ☐ST Note ☐HX/PE
    ☐Other: _____
26. SENDING FACILITY CONTACT: _____ Title _____ Unit _____ Phone _____
    REC'G FACILITY CONTACT (if known): _____ Title _____ Unit _____ Phone _____
27. FORM PREFILLED BY (if applicable): _____ Title _____ Unit _____ Phone _____
28. FORM COMPLETED BY: _____ Title _____ Phone _____

Northeast Health Care Quality Foundation. ***Transfer Checklist and Feedback*** **and** ***Transitions Initiative Log***

Transfer Checklist and Feedback

Sending Facility:_____ Receiving Facility: _____

Person & Phone Number of Receiving Facility Requesting Info: _____

Patient's Name_____ Date: __/__/__ Time: _ _:_ _ (military)

☐ **All** information necessary to treat the patient was **received**.
☐ The following information necessary to treat the patient was **not received or was incomplete**:

☐ Face sheet with demographic and insurance information	☐ Discharge Summary or discharge paperwork
☐ Medication list missing ☐ Medication list incomplete, missing: _____	☐ Treatment orders (wound care, nursing care, OT/PT/Speech therapy, lab orders)
☐ Reason for transfer	☐ H & P or Medical History
☐ Face to Face	☐ Verbal Report or Nurse to Nurse Report
☐ Advance Directives and/or Code Status	☐ Inadequate supplies for care
☐ Safety Concerns/Special Treatments:	☐ Other:

Please fax form **within 1 business day** to:
1. Contact person listed below *and*
2. NHCQF Fax

Form received on: ____/____/____ To be completed and resent **ONLY** if all information was not received.
RESPONSE: The following is now in place to prevent these deficiencies from occurring with future referrals:

_____

_____

_____

_____

_____

_____

_____

Person completing form: _____

*Please fax form **within 5 days** to Contact Person at Receiving Facility **and** NHCQF Contact*

This material was prepared by Northeast Health Care Quality Foundation (NHCQF), the Medicare Quality Improvement Organization (QIO) for Maine, New Hampshire and Vermont, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 0812-1152-C.8.N

New York. Catskill Regional Medical Center. SBAR Transfer Form

Catskill
REGIONAL MEDICAL CENTER

Addendum to Medical/Nursing Discharge Summary & PRI for Long Term Care

S *Situation*

Date/Time:

Discharge to Nursing Home

Report given to:

B *Background*

Admitting Diagnoses

Allergies:

Isolation Status: ☐None ☐Contact ☐Airborne ☐Droplet

Procedures performed

Code Status:

Advanced Directives: ☐DNR ☐ DNI ☐MOLST ☐Living Will ☐HC Proxy ☐Copies Provided

Pneumococcal Vaccine Date **Influenza Vaccine Date**

A *Assessment*

Neuro Status: Fall Risk: ☐Yes ☐No

Admission Weight _____ Discharge Weight _____

O_2 _____ via _____

☐PICC/Central Line Measurements

☐Nasogastric tube ☐PEG ☐J-P Drain ☐Hemovac ☐

Visual/Hearing Impairments:

Transfer Status: ☐Self ☐Assist

WT Bearing Status & Activities:

Ability to Stand: ☐Independently ☐With assistance ☐Unable

Assistive devices needed: ☐ Cane ☐Quad Cane ☐Crutches ☐Walker ☐

Skin Concerns:

Wounds/Surgical Incisions: ☐ Yes ☐ No

Last Ate/Drank

Last Void Foley Date inserted

Last BM:

R *Recommendation*

Treatments/Dressing Changes

Durable Med Equipment Uses

Special considerations:

Q *Questions*

For Questions Call discharge nurse: _____

at 845-794-3300 at extension: _____ or 845-887-5530 at extension: _____

FAX this to Nursing Home. Fax number_____

Virginia Universal Model Transfer Form

http://www.vhha.com/patienttransfer.html

Direct link to form: http://www.vhha.com/documents.html?id=346

MODEL TRANSFER FORM: NURSING FACILITY TO EMERGENCY DEPARTMENT/HOSPITAL

Date: _____ **Time of Transfer:** _____

The back of this form must be completed when the patient is transferred back to the nursing facility

Patient Information

Name: _____ Emergency Contact: _____

Primary Language: _____ Relationship to Patient: _____

Code Status: ☐ Full Code ☐ DNR Phone: _____

Notified of Transfer: ◯ Yes Date: _____ ◯ No

Name of Nursing Facility and Unit #: _____ Phone: _____

Address: _____

Reason for Transfer/Actions Taken Prior to Transfer: _____

_____

Attending Physician: _____ Phone: _____

Vital Signs at Transfer

HT: _____ WT: _____ BP: _____ TEMP: _____

PULSE: _____ PULSE OX: _____ RESP: _____ Blood Sugar: _____

PAIN: ◯ Yes Rating 0-10 _____ SITE(S) of Pain: _____ ◯ No Pain

TREATMENT: _____

Baseline Mental Status

☐ Alert ☐ Oriented ☐ Confused ☐ Demented ☐ Delirious ☐ Lethargic ☐ Comatose ☐ Agitated ☐ Assaultive ☐ Wanders

Does the Patient have decision-making capacity? ◯ Yes ◯ No

If not, who has authority to make decisions for the patient?

Name: _____ Phone: _____ Relationship to patient: _____

Attachments

☐ Face Sheet ☐ MAR ☐ TAR (treatments) ☐ POS (doctor's orders) ☐ Pertinent Labs ☐ X-rays, EKGs, Scans ☐ Surgical Reports

☐ Copy of Signed DNR Order ☐ Original DDNR ☐ Advance Directive ☐ Skin Guide ☐ Other _____

At Risk For

☐ None known ☐ Falls ☐ Skin Breakdown ☐ Seizures ☐ Communicable disease ☐ Aspiration

☐ Hypo/Hyperglycemia ☐ Harm to Self ☐ Harm to Others ☐ Other _____

Special Conditions

Skin Wounds: ◯ Yes (Attach Skin Guide) ◯ No

Stage(s) ◯ 1 ◯ 2 ◯ 3 ◯ 4 Wound VAC ◯ Yes ◯ No

Needs a Special Mattress? ◯ Yes ◯ No

IV's in Last 14 days ◯ Yes ◯ No

Foley Catheter ◯ Yes Date inserted: _____ ◯ No

Oxygen Dependence: ◯ Yes ◯ No

☐ Pacemaker ☐ Internal Cardiac Defibrillator

☐ Other Implanted Devices (PICC Lines, Portacath, etc.)

_____

Date of last pneumovac: _____

Date of last flu shot: _____

Date of last Tetanus shot: _____

Isolation Precautions: ☐ None ☐ Contact ☐ Droplet ☐ Airborne

☐ MRSA ☐ VRE ☐ C-Diff ☐ Other _____

Special Diet (e.g. Thickened liquids)

_____

_____

Artificial Feeding ◯ Yes ◯ No

Baseline ADLs ☐ Walking ☐ Independent ☐ Dependent ☐ Transferring

Allergies: ❑ Yes (List Below) ❑ No

_____

_____

_____

_____

_____

Print Name of Person Completing Form: _____ Phone: _____

Signature: _____ Date: _____

Rev: 06.02.09

MODEL TRANSFER FORM: EMERGENCY DEPARTMENT/HOSPITAL TO NURSING FACILITY

Date: _____ **Time of Transfer:** _____

This form must be completed when the patient is transferred back to the nursing facility

Patient Name: _____

Is the Transfer Information Attached? ○ Yes ○ No (See "Attachments" Section Below)

IV Treatment: ○ Yes ○ No

Access: _____

Foley Catheter: ○ Yes Date Inserted _____ ○ No History of UTI: ○ Yes ○ No

Diagnosis/Findings:

_____

_____

_____

Consultation(s):

_____

_____

_____

Treatment/Continued Care Recommendations:

_____

_____

_____

Copy of Treatment Documentation Attached: ○ Yes ○ No

Attachments Returned with Patient

☐ Face Sheet ☐ MAR ☐ TAR (treatments) ☐ POS (doctor's orders) ☐ Pertinent ED Test Results

☐ Copy of Signed DNR Order ☐ Original DDNR ☐ Advance Directive ☐ Skin Guide ☐ Other _____

☐ Case Reviewed with Primary Care Provider (MD, NP, PA) Name: _____

Contact Info:_____

Medications

_____

_____

_____

_____

New Risks

☐ Falls ☐ Skin Breakdown ☐ Seizures ☐ Communicable disease ☐ Aspiration ☐ Hypo/Hyperglycemia

☐ Harm to Self ☐ Harm to Others ☐ Other _____

Skin Wounds: ○ Yes (If yes, attach Skin Guide) ○ No

Stage(s) ☐ 1 ☐ 2 ☐ 3 ☐ 4 Needs a Special Mattress? ○ Yes ○ No

Emergency Department/Hospital Contact Information

Name/Address of Hospital: _____

_____ Phone: _____

Print Name of Person Completing Form: _____ Phone: _____

Signature: _____ Date: _____

Rev: 06.02.09