

## 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.<sup>1-3</sup> They are also a priority target for safety and quality improvement efforts to reduce preventable hospital readmissions and other adverse events and outcomes.<sup>4-6</sup> 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.<sup>4,7-10</sup>

### 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.<sup>4,11-14</sup> 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.”<sup>14</sup> Additionally, “transfer to the emergency department (ED) is a serious adverse event,” according to Grunier et al, who also note that “transitions between health care settings are increasingly recognized as a time when older adults, especially those with complex needs, are particularly vulnerable to complication or error.”<sup>15, p.203</sup>

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.”<sup>16, p.16</sup> 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.<sup>17-20</sup>

### ***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.<sup>16,21</sup> 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.<sup>22</sup> 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.<sup>7</sup> 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<sup>17</sup> 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.<sup>23,24</sup> Patients with an “information gap” were associated with 1.2 hours longer stay in the emergency department than patients without missing information.<sup>23</sup> 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.<sup>25</sup> 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."<sup>25, p.14</sup> 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.<sup>26</sup> 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."<sup>27</sup> 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.<sup>28,29</sup>

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.<sup>26</sup> Interestingly, only one study evaluated a structured format and standardized approach known by its acronym DeMIST (**D**emographics, **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.<sup>30</sup> 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.<sup>31</sup> 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.<sup>4,16,17,26,31-38</sup> 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.<sup>39</sup>

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).<sup>38</sup> 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.<sup>36,40</sup>

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.<sup>32-35,41-46</sup> 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<sup>34</sup> 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.<sup>35</sup> 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.<sup>47</sup> 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.<sup>48,49</sup> 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 identify testable solutions (transfer forms, checklists, etc.) that would help improve the quality and safety of transfers between NHs and EDs.<sup>9</sup> 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.<sup>50</sup> 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.<sup>16</sup> AMDA also recommends the use of the INTERACT II transfer tool (**INTER**ventions to **REDUCE** Acute Care Transfers). 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.<sup>51,52</sup> 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.<sup>53</sup> (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 vulnerable to complication or error. The NF, EMS, and rural hospital ED can improve patient safety by the streamlining and improving 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.<sup>16</sup>

### *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.<sup>39</sup> 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 **Virginia**, 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.<sup>22</sup> 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.

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### **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

## References

1. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.
2. Kohn LT, Corrigan JM, Donaldson MS, Eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.
3. Wachter RM. *Understanding Patient Safety*. New York: McGraw-Hill; 2008.
4. Terrell KM , Miller DK. Critical Review of Transitional Care Between Nursing Homes and Emergency Departments. *Annals of Long Term Care*. 2007; 15(2):33-38. <http://www.annalsoflongtermcare.com/article/6782>
5. Mor V, Intrator O, Feng Z, Grabowski DC. The Revolving Door Of Rehospitalization From Skilled Nursing Facilities. *Health Aff*. 2010; 29(1):57-64. <http://content.healthaffairs.org/cgi/content/abstract/29/1/57>
6. Powell SK. Handoffs and Transitions of Care: Where Is the Lone Ranger's Silver Bullet? *Lippencotts Case Management*. 2006; 11(5):235-7.
7. Klingner J , Moscovice I. Development and Testing of Emergency Department Patient Transfer Communication Measures. *J Rural Health*. 2012; 28(1):44-53. [doi: 10.1111/j.1748-0361.2011.00374.x](https://doi.org/10.1111/j.1748-0361.2011.00374.x)
8. Wong RY. Transferring Nursing Home Residents to Acute Care Hospital--to Do or Not to Do, That Is the Question. *J Am Med Dir Assoc*. 2010; 11(5):304-5.
9. Terrell KM, Miller DK. Strategies to Improve Care Transitions Between Nursing Homes and Emergency Departments. *J Am Med Dir Assoc*. 2011; 12(8):602-5.
10. Castle NG, Mor V. Hospitalization of Nursing Home Residents: A Review of the Literature, 1980-1995. *Med Care Res Rev*. 1996; 53(2):123-48.
11. Gruneir A , Bell CM, Bronskill SE, et al. Frequency and Pattern of Emergency Department Visits by Long-Term Care Residents--a Population-Based Study. *J Am Geriatr Soc*. 2010; 58(3):510-517.
12. Gruneir A , Silver MJ, Rochon PA. Emergency Department Use by Older Adults: a Literature Review on Trends, Appropriateness, and Consequences of Unmet Health Care Needs. *Med Care Res Rev*. 2011; 68(2):131-155.
13. Carter MW , Datti B, Winters JM. ED Visits by Older Adults for Ambulatory Care-Sensitive and Supply-Sensitive Conditions. *Am J Emerg Med*. 2006; 24(4):428-34.
14. Wilson D, Truman C. Comparing the Health Services Utilization of Long-Term-Care Residents, Home-Care Recipients, and the Well Elderly. *Can J Nurs Res*. 2005; 37(4):138-54.
15. Gruneir A , Bronskill S, Bell C, et al. Recent Health Care Transitions and Emergency Department Use by Chronic Long Term Care Residents: a Population-Based Cohort Study. *J Am Med Dir Assoc*. 2012; 13(3):202-6.
16. American Medical Directors Association. *Policy Resolution H 10: Improving Care Transitions Between the Nursing Facility and the Acute-Care Hospital Settings*. Columbia, MD: AMDA, Public Policy Committee; March 2010. <http://www.amda.com/governance/whitepapers/H10.pdf>
17. Jones JS, Dwyer PR, White LJ, Firman R. Patient Transfer From Nursing Home to Emergency Department: Outcomes and Policy Implications. *Acad Emerg Med*. 1997; 4(9):908-915. <http://dx.doi.org/10.1111/j.1553-2712.1997.tb03818.x>

18. Caffrey C. *Potentially Preventable Emergency Department Visits by Nursing Home Residents: United States, 2004*. (NCHS Data Brief No. 33). Hyattsville, MD: Centers for Disease Control and Prevention; April 2010. <http://www.cdc.gov/nchs/data/databriefs/db33.pdf>
19. Maslow K, Ouslander JG. *Measurement of Potentially Preventable Hospitalizations*. (White Paper). Washington, DC: Long Term Care Quality Alliance; February 2012. [http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/PreventableHospitalizations\\_021512\\_2.pdf](http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/PreventableHospitalizations_021512_2.pdf)
20. Kayser-Jones JS, Wiener CL, Barbaccia JC. Factors Contributing to the Hospitalization of Nursing Home Residents. *Gerontologist*. 1989; 29(4):502-10.
21. Shah F, Burack O, Boockvar KS. Perceived Barriers to Communication Between Hospital and Nursing Home at Time of Patient Transfer. *J Am Med Dir Assoc*. 2010; 11(4):239-45.
22. Kelly NA, Mahoney DF, Bonner A, O'Malley T. Use of a Transitional Minimum Data Set (TMDS) to Improve Communication Between Nursing Home and Emergency Department Providers. *J Am Med Dir Assoc*. 2012; 13(1):85.e9-15.
23. Stiell A, Forster AJ, Stiell IG, van Walraven C. Prevalence of Information Gaps in the Emergency Department and the Effect on Patient Outcomes. *CMAJ*. 2003; 169(10):1023-8.
24. Cwinn MA, Forster AJ, Cwinn AA, et al. Prevalence of Information Gaps for Seniors Transferred From Nursing Homes to the Emergency Department. *CJEM*. 2009; 11 (5):462-71.
25. Cortes TA, Wexler S, Fitzpatrick JJ. The Transition of Elderly Patients Between Hospitals and Nursing Homes. Improving Nurse-to-Nurse Communication. *J Gerontol Nurs*. 2004; 30(6):10-5; Checklist: p.13.
26. Bost N, Crilly J, Wallis M, Patterson E, Chaboyer W. Clinical Handover of Patients Arriving by Ambulance to the Emergency Department - a Literature Review. *Int Emerg Nurs*. 2010; 18(4):210-20.
27. Owen C, Hemmings L, Brown T. Lost in Translation: Maximizing Handover Effectiveness Between Paramedics and Receiving Staff in the Emergency Department. *Emerg Med Australas*. 2009; 21(2):102-7.
28. Suserud BO, Bruce K. Ambulance Nursing. Part Three. *Emerg Nurse*. 2003; 11 (2):16-21.
29. Bruce K, Suserud BO. The Handover Process and Triage of Ambulance-Borne Patients: the Experiences of Emergency Nurses. *Nurs Crit Care*. 2005; 10(4):201-9.
30. Talbot R, Bleetman A. Retention of Information by Emergency Department Staff at Ambulance Handover: Do Standardised Approaches Work? *Emerg Med J*. 2007; 24(8):539-42.
31. Iedema R, Ball C, Daly B, et al. Design and Trial of a New Ambulance-to-Emergency Department Handover Protocol: 'IMIST-AMBO'. *BMJ Qual Saf*. 2012; 21 (8):627-33.
32. Pauls MA, Singer PA, Dubinsky I. Communicating Advance Directives From Long-Term Care Facilities to Emergency Departments. *J Emerg Med*. 2001; 21(1):83-9.
33. Gaddis GM. Elder Care Transfer Forms. *Acad Emerg Med*. 2005; 12(2):160-161. <http://dx.doi.org/10.1111/j.1553-2712.2005.tb00857.x>
34. Terrell KM, Brizendine EJ, Bean WF, et al. An Extended Care Facility-to-Emergency Department Transfer Form Improves Communication. *Acad Emerg Med*. 2005; 12(2):114-8.
35. Terrell KM, Miller DK. Challenges in Transitional Care Between Nursing Homes and Emergency Departments. *J Am Med Dir Assoc*. 2006; 7(8):499-505.
36. Davis MN, Brumfield VC, Smith ST, Tyler S, Nitschman J. A One-Page Nursing Home to Emergency Room Transfer Form: What a Difference It Can Make During an Emergency. *Annals of Long Term Care*. 2005; 13(11):online. <http://www.annalsoflongtermcare.com/article/4928>

37. Fernandes CMB. Geriatric Care in the Emergency Department. *Acad Emerg Med*. 2005; 12(2):158-9.
38. 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.
39. Tupper J, Gray C, Pearson K, Coburn A. *SAFER: Standardizing Admissions for Elderly Residents*. Poster presentation at the AHRQ Annual Conference; 2012, September; Bethesda, MD.
40. Davis MN, Smith ST, Tyler S. Improving Transition and Communication Between Acute Care and Long-Term Care: a System for Better Continuity of Care. *Annals of Long Term Care*. 2005; 13(2):25-32. <http://www.annalsoflongtermcare.com/article/4100>
41. Gillespie SM, Gleason LJ, Karuza J, Shah MN. Health Care Providers' Opinions on Communication Between Nursing Homes and Emergency Departments. *J Am Med Dir Assoc*. 2010; 11(3):204-10.
42. Hustey FM, Palmer RM. Implementing an Internet-Based Communication Network for Use During Skilled Nursing Facility to Emergency Department Care Transitions: Challenges and Opportunities for Improvement. *J Am Med Dir Assoc*. 2012; 13(3):249-53.
43. Madden C, Garrett J, Busby-Whitehead J. The Interface Between Nursing Homes and Emergency Departments: A Community Effort to Improve Transfer of Information. *Acad Emerg Med*. 1998; 5(11):1123-1126. <http://dx.doi.org/10.1111/j.1553-2712.1998.tb02677.x>
44. Boockvar K, Fridman B, Marturano C. Ineffective Communication of Mental Status Information During Care Transfer of Older Adults. *J Gen Intern Med*. 2005; 20(12):1146-1150. <http://dx.doi.org/10.1111/j.1525-1497.2005.00262.x>
45. Hustey FM. Care Transitions Between Nursing Homes and Emergency Departments: A Failure to Communicate. *Annals of Long Term Care*. 2010; 18(4):17-19. <http://www.annalsoflongtermcare.com/content/care-transitions-between-nursing-homes-and-emergency-departments-a-failure-communicate>
46. Kirsebom M, Wadensten B, Hedstrom M. Communication and Coordination During Transition of Older Persons Between Nursing Homes and Hospital Still in Need of Improvement. *J Adv Nurs*. 2012. [doi: 10.1111/j.1365-2648.2012.06077](https://doi.org/10.1111/j.1365-2648.2012.06077)
47. Dalawari P, Duggan J, Vangimalla V, Paniagua M, Armbrecht ES. Patient Transfer Forms Enhance Key Information Between Nursing Homes and Emergency Department. *Geriatr Nur (Lond)*. 2011; 32(4):270-275.
48. Missouri Long-Term Care Best Practice Coalition. Continuity of Care Transfer Project. *Best Practice Guide to Action: Strategies and Tools to Improve the Transfer Process*. Missouri Department of Health and Senior Services; 2008. <http://health.mo.gov/seniors/bestpracticescoalition/pdf/ContinuityofCareTransferProject.pdf>
49. Emergency Nurses Association. *Safer Handoff: A Practical Guide to Safer Handoff of Older Adult Patients Between Long-Term Care Facilities and Emergency Departments*. Des Plaines, IL: ENA; 2010. <http://www.ena.org/IQSIP/Safety/Patient/Pages/SaferHandoff.aspx>
50. Edelstein T, Moles D. State Makes Universal Transfer Form Mandatory. *Provider Magazine*. 2012; online(January). <http://www.providermagazine.com/archives/archives-2012/Pages/0112/State-Makes-Universal-Transfer-Form-Mandatory.aspx>
51. Ouslander JG, Lamb G, Tappen R, et al. Interventions to Reduce Hospitalizations From Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project. *J Am Geriatr Soc*. 2011; 59(4):745-53.
52. Ouslander JG, Lamb G, Perloe M, et al. Potentially Avoidable Hospitalizations of Nursing Home Residents: Frequency, Causes, and Costs. *J Am Geriatr Soc*. 2010; 58(4):627-35.
53. Centers for Medicare and Medicaid Innovation. *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*. [Web Page]. 2012, September 27. Available at: <http://www.innovations.cms.gov/initiatives/rahnfr/index.html>. Accessed October 2, 2012.

## Appendix: Sample Transfer Forms and Checklists

American Medical Directors Association (AMDA). *Universal Transfer Form*, revised 2012. <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](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 <sup>1</sup>

- |          |                                 |
|----------|---------------------------------|
| 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	<input type="checkbox"/>	<input type="checkbox"/>
PEG tube feeding	<input type="checkbox"/>	<input type="checkbox"/>
Further hospitalization	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_



Dedicated To Long Term Care Medicine

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: \_\_\_\_\_

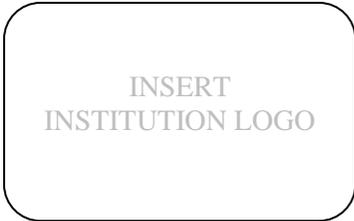
Date form completed: / /

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)**



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. <b>Completed</b> copy of the <i>Patient Handoff Form</i> .
	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) — <i>Dosage, frequency, route, date started, usual administration times, date and time of last dose given</i>
	12. Advanced directives
	13. Code Status — <i>Copy of signed DNR</i>
	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

DATE OF TRANSFER: \_\_\_\_/\_\_\_\_/\_\_\_\_

TIME OF TRANSFER: \_\_\_\_:\_\_\_\_ AM PM

**PATIENT INFORMATION**

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Street Address City

\_\_\_\_\_  
State/Province Zip/Postal Code

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DOB

GENDER: 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**

**SECONDARY DIAGNOSIS**

**PRIMARY DIAGNOSIS**

**CODE STATUS**

Copy of signed DNR:  Yes  No DNR Status:  CC  CC Arrest Full Code:  Yes  No  
DNR Must Be Sent

**ACUTE CHANGES FROM BASELINE ASSOCIATED WITH TRANSFER**

**VITAL SIGNS AT TRANSFER — TIME TAKEN: \_\_\_\_:\_\_\_\_ AM PM**

BP: \_\_\_\_/\_\_\_\_ TEMP: \_\_\_\_ PULSE: \_\_\_\_ RESP: \_\_\_\_ SAO<sub>2</sub>: \_\_\_\_  O<sub>2</sub> Therapy

**IMMUNIZATION STATUS**  Attached

T.S.T. (PPD)	Date: _____	Results: _____	Hepatitis A:	Date: _____	<input type="checkbox"/> UNK
Influenza	Date: _____	<input type="checkbox"/> UNK	Hepatitis B:	Date: _____	<input type="checkbox"/> UNK
Pneumococcal	Date: _____	<input type="checkbox"/> UNK	Measles, Mumps, Rubella	Date: _____	<input type="checkbox"/> UNK
Meningococcal	Date: _____	<input type="checkbox"/> UNK	Varicella	Date: _____	<input type="checkbox"/> UNK
D.T.P.	Date: _____	<input type="checkbox"/> UNK	Inactivated Poliovirus	Date: _____	<input type="checkbox"/> UNK
Tetanus	Date: _____	<input type="checkbox"/> UNK			

<b>TB Test</b>	Date	Type	Result	<b>Biochem</b>	Date	Result
<b>Chest X-Ray</b>	Date	Result		<b>Urinalysis</b>	Date	Result
<b>C.B.C.</b>	Date	Result		<b>Fasting Glucose</b>	Date	Result

**ALLERGIES**  None  UNK : Allergic To: \_\_\_\_\_ Reaction:  UNK  
Allergic To: \_\_\_\_\_ Reaction:  UNK  
Allergic To: \_\_\_\_\_ Reaction:  UNK

**ISOLATION/PRECAUTION**

<input type="checkbox"/> None	<input type="checkbox"/> MRSA	Date: _____	Site: _____
<input type="checkbox"/> Contact	<input type="checkbox"/> VRE	Date: _____	Site: _____
<input type="checkbox"/> Droplet	<input type="checkbox"/> ESBL	Date: _____	Site: _____
<input type="checkbox"/> Airborne	<input type="checkbox"/> Other	Date: _____	
	<input type="checkbox"/> 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

**AT RISK ALERTS**

- |                                       |                                                      |                                                   |
|---------------------------------------|------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Fall         | <input type="checkbox"/> Harm to Others (assaultive) | <input type="checkbox"/> Restraints               |
| <input type="checkbox"/> Harm to Self | <input type="checkbox"/> Elopement                   | <input type="checkbox"/> Skin Failure (Breakdown) |
| <input type="checkbox"/> Seizure      | <input type="checkbox"/> Aspiration                  | Braden Score: _____                               |
|                                       | <input type="checkbox"/> Impaired Safety Awareness   | <input type="checkbox"/> Other                    |

**TREATMENT RECEIVED WITHIN LAST 14 DAYS**

- |                                        |                                            |                                           |
|----------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Chemotherapy  | <input type="checkbox"/> Oxygen Therapy    | <input type="checkbox"/> Ventilator       |
| <input type="checkbox"/> Dialysis      | <input type="checkbox"/> Transfusions      | <input type="checkbox"/> Tracheotomy Care |
| <input type="checkbox"/> IV Medication | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> 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**

- |                                         |                                        |
|-----------------------------------------|----------------------------------------|
| <input type="checkbox"/> Feeding Tube   | <input type="checkbox"/> Ostomy        |
| <input type="checkbox"/> Foley Catheter | <input type="checkbox"/> Implant Defib |
| <input type="checkbox"/> Tracheotomy    | <input type="checkbox"/> Pacemaker     |
| <input type="checkbox"/> Central Line   |                                        |

**DECISION MAKING**

- Independent
- Moderately Impaired
- Severely Impaired

**ITEMS SENT WITH PATIENT**

*(Assistive Devices)*

- |                                      |                                   |                                                           |
|--------------------------------------|-----------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Glasses     | <input type="checkbox"/> Cane     | <input type="checkbox"/> Prosthesis:      Left      Right |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Crutches | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Dentures    | <input type="checkbox"/> Walker   |                                                           |

**DIET**

- |                      |                                      |                                           |                                           |                                       |
|----------------------|--------------------------------------|-------------------------------------------|-------------------------------------------|---------------------------------------|
| Type of Diet:        | <input type="checkbox"/> Regular     | <input type="checkbox"/> Mechanical Soft  | <input type="checkbox"/> Thickened Liquid | <input type="checkbox"/> Other: _____ |
| Diet Restrictions:   | <input type="checkbox"/> Cardiac     | <input type="checkbox"/> Renal            | <input type="checkbox"/> Diabetic         | <input type="checkbox"/> Other: _____ |
| Feeding Requirement: | <input type="checkbox"/> Independent | <input type="checkbox"/> Needs Assistance | <input type="checkbox"/> Dependent        | <input type="checkbox"/> Tube Feed    |

**SPECIAL CARE ORDERS**

- Enemas PRN
- O<sub>2</sub> ----- 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<sub>2</sub>: \_\_\_\_\_ SAO<sub>2</sub>: \_\_\_\_\_ 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**  Living Will  No transfusions  
*Copy Must Be Sent*  DPOA for Healthcare  Other

**FORM COMPLETED BY:** Name: \_\_\_\_\_ Title: \_\_\_\_\_ Signature: \_\_\_\_\_

**REPORT CALLED IN BY:** Name: \_\_\_\_\_ Title: \_\_\_\_\_

**REPORT CALLED TO:** Name: \_\_\_\_\_ Title: \_\_\_\_\_

**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



Date:		DOB:	
Resident's last name:		Resident's first name:	Middle:
Transferring facility:		Transferring facility phone:	
Receiving hospital:		Hospital Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Destination: <input type="checkbox"/> emergency department <input type="checkbox"/> admitting <input type="checkbox"/> outpatient <input type="checkbox"/> clinic			
Resident's primary physician:		Has physician been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family member's/guardian name:		Family member/guardian contacted? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valuables with resident?
A living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clean/Dry when leaving?
Orders to limit emergency treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A legal guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A Do Not Resuscitate Comfort Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A DNRCC arrest?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Please provide baseline documentation for each*

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

*Vitals and baseline:*

Temp:	Pulse:	Resp:	BP:	Age:	Height:	Weight:
Time taken:		Pox:	O2:	Pain Level:	Location:	
Resistant organism? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes: <input type="checkbox"/> MRSA <input type="checkbox"/> C-Diff <input type="checkbox"/> VRE <input type="checkbox"/> other			
Communicable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, describe?			
Flu Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Pneumonia vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			
Tetanus? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:			Copy of immunization record attached? <input type="checkbox"/> Yes <input type="checkbox"/> 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%202019.pdf](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%202019.pdf)

# Acute Care Transfer Document Checklist

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.**

Amulance Driver Signature *(optional)* \_\_\_\_\_

# Nursing Home to Hospital Transfer Form

**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) \_\_\_\_\_

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



**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** \_\_\_\_\_

**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: \_\_\_\_\_  
 \_\_\_\_\_

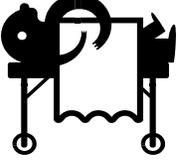
Level of Care  
 Secure Unit   
 Skilled:   
 Long Term:   
 Res Care:   
 ADS:

**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 \_\_\_\_\_ Mayo Clinic Number \_\_\_\_\_  
Last First Middle

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

**Nursing Information**

ACTIVITIES OF DAILY LIVING

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

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	

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

PART 1 - SEND WITH PATIENT TO HOSPITAL

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 <input type="checkbox"/> 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 \_\_\_\_\_

<b>CODE STATUS</b> <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/> DNR <input type="checkbox"/> See DNR Form	<b>ALLERGIES</b> <input type="checkbox"/> No Known Allergies <input type="checkbox"/> See MAR
---------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

<input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Guardian Name _____ Phone _____	Advance Directives <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Health Care Decision Maker or Local Contact Notified of Transfer Name _____ Phone _____	Resident able to make own decisions <input type="checkbox"/> Yes <input type="checkbox"/> No
	Speaks English <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify _____
	Religious/Literacy Concerns <input type="checkbox"/> 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

<b>Impairments</b> <input type="checkbox"/> Mental (describe) _____	<input type="checkbox"/> Speech (describe) _____	<input type="checkbox"/> Hearing (describe) _____	<input type="checkbox"/> Vision (describe) _____	<input type="checkbox"/> Sensation (describe) _____
---------------------------------------------------------------------	--------------------------------------------------	---------------------------------------------------	--------------------------------------------------	-----------------------------------------------------

<b>Disabilities</b> <input type="checkbox"/> Amputation (describe) _____	<input type="checkbox"/> Prosthesis (describe) _____	<input type="checkbox"/> Contracture (describe) _____	<input type="checkbox"/> 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) \_\_\_\_\_

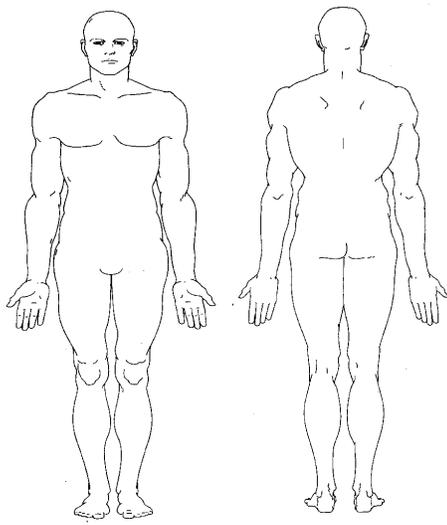
**Infection**  MRSA Site  VRE Site  C. difficile  UTI  Other \_\_\_\_\_

**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 <input type="checkbox"/> EMS <input type="checkbox"/> Family <input type="checkbox"/> 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](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*

4. LANGUAGE:  English  Other: \_\_\_\_\_

PATIENT DOB (mm/dd/yyyy): \_\_\_\_\_ GENDER  M  F

5. PHYSICIAN NAME \_\_\_\_\_ PHONE \_\_\_\_\_

6. CODE STATUS:  DNR  DNH  DNI  
 Out of Hospital DNR Attached

7. CONTACT PERSON \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
PHONE (Day) \_\_\_\_\_ (Night) \_\_\_\_\_ (Cell) \_\_\_\_\_  
NAME OF  HEALTH CARE REPRESENTATIVE/PROXY  
OR  LEGAL GUARDIAN, IF NOT CONTACT PERSON: \_\_\_\_\_  
PHONE (Day) \_\_\_\_\_ (Night) \_\_\_\_\_ (Cell) \_\_\_\_\_

Check if Contact Person:  
 Health Care Representative/Proxy  Legal Guardian

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: \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_

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 \_\_\_\_\_ Unit \_\_\_\_\_ 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**:

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

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Person completing form: \_\_\_\_\_

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

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

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

<b>S</b> <i>Situation</i>	Date/Time: _____
	Discharge to _____ Nursing Home
	Report given to: _____
<b>B</b> <i>Background</i>	Admitting Diagnoses _____
	Allergies: _____
	Isolation Status: <input type="checkbox"/> None <input type="checkbox"/> Contact <input type="checkbox"/> Airborne <input type="checkbox"/> Droplet
	Procedures performed _____
	Code Status: _____
	Advanced Directives: <input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> MOLST <input type="checkbox"/> Living Will <input type="checkbox"/> HC Proxy <input type="checkbox"/> Copies Provided
	Pneumococcal Vaccine Date _____ Influenza Vaccine Date _____
<b>A</b> <i>Assessment</i>	Neuro Status: _____ Fall Risk: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Admission Weight _____ Discharge Weight _____
	O <sub>2</sub> _____ via _____
	<input type="checkbox"/> PICC/Central Line _____ Measurements _____
	<input type="checkbox"/> Nasogastric tube <input type="checkbox"/> PEG <input type="checkbox"/> J-P Drain <input type="checkbox"/> Hemovac <input type="checkbox"/>
	Visual/Hearing Impairments: _____
	Transfer Status: <input type="checkbox"/> Self <input type="checkbox"/> Assist
	WT Bearing Status & Activities: _____
	Ability to Stand: <input type="checkbox"/> Independently <input type="checkbox"/> With assistance <input type="checkbox"/> Unable
	Assistive devices needed: <input type="checkbox"/> Cane <input type="checkbox"/> Quad Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/>
	Skin Concerns: _____
	Wounds/Surgical Incisions: <input type="checkbox"/> Yes <input type="checkbox"/> No
Last Ate/Drank _____	
Last Void _____ Foley _____ Date inserted _____	
Last BM: _____	
<b>R</b> <i>Recommendation</i>	Treatments/Dressing Changes _____
	_____
	Durable Med Equipment Uses _____
<b>Q</b> <i>Questions</i>	Special considerations: _____
	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: <input type="checkbox"/> Yes (Attach Skin Guide) <input type="checkbox"/> No Stage(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Wound VAC <input type="checkbox"/> Yes <input type="checkbox"/> No Needs a Special Mattress? <input type="checkbox"/> Yes <input type="checkbox"/> No	IV's in Last 14 days <input type="checkbox"/> Yes <input type="checkbox"/> No Foley Catheter <input type="checkbox"/> Yes Date inserted: _____ <input type="checkbox"/> No Oxygen Dependence: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal Cardiac Defibrillator <input type="checkbox"/> Other Implanted Devices (PICC Lines, Portacath, etc.)	Date of last pneumovac: _____ Date of last flu shot: _____ Date of last Tetanus shot: _____
Isolation Precautions: <input type="checkbox"/> None <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Airborne <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C-Diff <input type="checkbox"/> Other _____	Allergies: <input type="checkbox"/> Yes (List Below) <input type="checkbox"/> No _____ _____ _____
Special Diet (e.g. Thickened liquids) _____ _____	
Artificial Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No Baseline ADLs <input type="checkbox"/> Walking <input type="checkbox"/> Independent <input type="checkbox"/> Dependent <input type="checkbox"/> Transferring	

Print Name of Person Completing Form: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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: \_\_\_\_\_