Your Hospital's Logo Here

METROPOLITAN WASHINGTON AREA INTER-AGENCY REFERRAL TRANSFER FORM

PATIENT NAME:		MR #:		TRANSFERRING FACILITY:		UNIT:	
ADDRESS / APT:		TEL #:		REFERRAL TO:			
CITY:	STATE:	ZIP:		TEL #:	FAX #:		
DOB:	AGE:	☐ M ☐ F MARITAL STATUS: S M W D	SSN #:	MEDICARE ID #:	A & B	A	B
RELATIVE / GUARDIAN:				MEDICAID ID & CODES:			
RELATIONSHIP:		TEL #:		OTHER INSURANCE NAME:		TEL #:	
ADDRESS / APT:				INSURANCE #:			
CITY:	STATE:	ZIP:		DATE ADMITTED:	DATE DISCHARGED:		
ALLERGIES:				SKIN INTACT? ☐ Y ☐ N IF "N" (NO), SKIN CARE SHEET ATTACHED?		☐ Y ☐ N	
PRIMARY DIAGNOSIS:							
SECONDARY DIAGNOSIS:							
VITAL SIGNS:	TEMP:	P:	R:	B / P:	R / L:	SIT / LIE / STAND	
CHIEF COMPLAINT:							

SERVICES	DESCRIPTION OF THERAPY	WEIGHT BEARING STATUS
☐ PHYSICAL THERAPY		☐ NON-WEIGHT BEARING
☐ OCCUPATIONAL THERAPY		☐ PARTIAL-WEIGHT BEARING
☐ SPEECH THERAPY		☐ FULL-WEIGHT BEARING
☐ RESPIRATORY THERAPY		
☐ COMPANION		
☐ DIALYSIS	FREQUENCY: LOCATION: TEL #:	

SELF-CARE STATUS:		INDEP	ASSIST	UNABLE
ADLS	BED TO CHAIR			
	WALKING			
	STAIRS			
	WHEELCHAIR			
	CRUTCHES			
	WALKER			
	BATHE			
	DRESS			
	FEED			
	BRUSHING TEETH			
	SHAVING			
	TOILET			
	COMMODE			
	BEDPAN / URINAL			
	RX ADMIN			

DISABILITIES	
TYPE	DESCRIBE
☐ AMPUTATION	
☐ PARALYSIS	
☐ CONTRACTURES	
☐ OTHER	

COMMUNICAT'NS	SOCIAL
☐ UNABLE TO WRITE	☐ WORKS IN GROUPS
☐ UNABLE TO SPEAK	☐ LONER
☐ UNDERSTANDS SPEECH	
☐ UNDERSTANDS ENGLISH	
☐ IF NO, SPECIFY LANGUAGE	
☐ READS	
☐ OTHER	

SENSORY IMPAIRMENT	
TYPE	EXPLAIN
☐ SPEECH	
☐ HEARING	
☐ VISION	
☐ SENSATION	
☐ OTHER	

MENTAL STATUS	
☐ ALERT	☐ ORIENTED
☐ FORGETFUL	☐ WANDERS
☐ CONFUSED	☐ SUNDOWNER
☐ WITHDRAWN	☐ DIFFICULTY SLEEPING

ELIMINATION		
☐ OSTOMY	INCONTINENCE	
CATHETER (URINARY)	☐ BLADDER	☐ BOWEL
SIZE:	DATE:	
DATE LAST BM		

PATIENT NAME: _____ SSN: _____

MEDICATIONS GIVEN DAY OF D/C	DOSE	FREQUENCY	MEDICATIONS GIVEN DAY OF D/C	DOSE	FREQUENCY

PSYCHO - SOCIAL INFORMATION:

☐ NO PROBLEMS NOTED ☐ COOPERATIVE ☐ DEPRESSED / WITHDRAWN ☐ ANGRY / HOSTILE
☐ REPORTS MOOD SWINGS ☐ SLEEP DISTURBANCE ☐ AGITATED ☐ ANXIOUS
☐ FLAT AFFECT ☐ LACK OF EVIDENT SUPPORT SYSTEMS

HYGIENE: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

TRANSPORTATION ISSUES (if any):

EXPLAIN NECESSARY DETAILS OF CLIENT / FAMILY TEACHING:

DIABETES:

WOUND:

MEDICATIONS:

NUTRITION / DIET / C-TUBE:

OSTOMY:

ADL / MOBILITY / TRANSFERS:

OTHER:

ADDITIONAL INFO:

PERSONAL BELONGINGS AND EQUIPMENT

☐ WITH PATIENT
☐ TO FAMILY

EYESIGHT: ☐ CONTACT LENS ☐ EYEGLASSES
DENTURES: ☐ FULL ☐ UPPER ☐ LOWER
ASSISTIVE DEVICE:
HEARING AID: ☐ LEFT ☐ RIGHT
PROSTHESIS (Type):

☐ CODE STATUS:
☐ ADVANCED DIRECTIVES ____ YES ____ NO ☐ SENT WITH PATIENT ____ YES ____ NO
☐ COPY OF MOST RECENT EKG SENT WITH PATIENT
☐ TB ____ NEGATIVE ____ POSITIVE ☐ STS ____ NEGATIVE ____ POSITIVE

PRINTED NAME:	SIGNATURE	PHONE:	DATE:

PATIENT NAME: _____ SSN: _____

SKIN STATUS

CLASSIFICATION of PRESSURE ULCERS: Adapted from AHCPR GUIDELINES

STAGE I: NONBLANCHABLE ERYTHEMA OF INTACT SKIN, THE HERALDING (BEGINNING) LESION OF SKIN ULCERATION. IN INDIVIDUALS WITH DARKER SKIN, DISCOLORATION OF THE SKIN, WARMTH, EDEMA, INDURATION OR HARDNESS MAY ALSO BE INDICATORS.

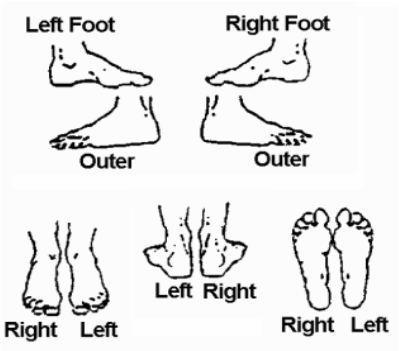
STAGE II: PARTIAL THICKNESS SKIN LOSS INVOLVING EDIMERMIS, DEMIS, OR BOTH.

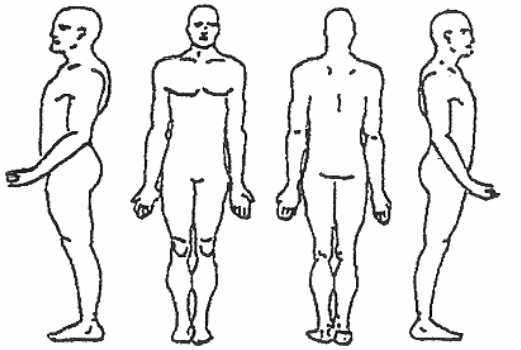
STAGE III: FULL THICKNESS SKIN LOSS INVOLVING DAMAGE TO OR NECROSIS OF SUBCUTANEOUS TISSUE THAT BY EXTEND DOWN TO, BUT NOT THROUGH, UNDERLYING FASCIA. THE ULCER PRESENTS CLINICALLY AS A DEEP CRATER WITH OR WITHOUT UNDERMINING ADJACENT TISSUE.

STAGE IV: FULL THICKNESS SKIN LOSS WITH EXTENSIVE DESTRUCTION, TISSUE NECROSIS, OR DAMAGE TO MUSCLE, BONE, OR SUPPORTING STRUCTURES (E.G., TENDOR OR JOINT CAPSULE).

UNSTAGED: WOUND BED COVERED WITH NECROTIC TISSUE

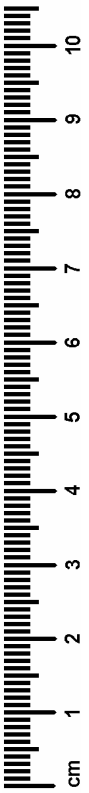
NUMBER EACH PRESSURE ULCER AND RECORD CHARACTERISTICS UNDER PRESSURE ULCERS DESCRIPTION CHART BELOW





PRESSURE ULCER CHART

PRESSURE ULCER #																	
STAGE																	
SIZE [L x W x D]																	
CRANULATION TISSUE																	
DRAINAGE																	
ODOR																	
TUNNELING																	
UNDERMINING																	
ESCHAR																	
SLOUGH																	
TREATMENT																	
ETIOLOGY FOR NON PRESSURE ULCERS																	



CURRENT TREATMENT

A = DEBRIDING AGENTS
B = TRANSPARENT FILM
C = HYDROCOILOID
D = ALGINATES
E = HYDROGEL
F = FOAMS
G = SILVADENE CREAM
H = NSS W / D
I = OTHER