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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:	<input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N IF "N" (NO), SKIN CARE SHEET ATTACHED? <input type="checkbox"/> Y <input type="checkbox"/> 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
<input type="checkbox"/> PHYSICAL THERAPY		<input type="checkbox"/> NON-WEIGHT BEARING
<input type="checkbox"/> OCCUPATIONAL THERAPY		<input type="checkbox"/> PARTIAL-WEIGHT BEARING
<input type="checkbox"/> SPEECH THERAPY		<input type="checkbox"/> FULL-WEIGHT BEARING
<input type="checkbox"/> RESPIRATORY THERAPY		
<input type="checkbox"/> COMPANION		
<input type="checkbox"/> DIALYSIS	FREQUENCY: LOCATION: TEL #:	

A D L S	SELF-CARE STATUS:	INDEP	ASSIST	UNABLE	DISABILITIES		SENSORY IMPAIRMENT	
					TYPE	DESCRIBE	TYPE	EXPLAIN
	BED TO CHAIR				<input type="checkbox"/> AMPUTATION		<input type="checkbox"/> SPEECH	
	WALKING				<input type="checkbox"/> PARALYSIS		<input type="checkbox"/> HEARING	
	STAIRS				<input type="checkbox"/> CONTRACTURES		<input type="checkbox"/> VISION	
	WHEELCHAIR				<input type="checkbox"/> OTHER		<input type="checkbox"/> SENSATION	
	CRUTCHES						<input type="checkbox"/> OTHER	
	WALKER							
	BATHE				COMMUNICAT'NS	SOCIAL	MENTAL STATUS	
	DRESS				<input type="checkbox"/> UNABLE TO WRITE	<input type="checkbox"/> WORKS IN GROUPS	<input type="checkbox"/> ALERT	<input type="checkbox"/> ORIENTED
	FEED				<input type="checkbox"/> UNABLE TO SPEAK	<input type="checkbox"/> LONER	<input type="checkbox"/> FORGETFUL	<input type="checkbox"/> WANDERS
	BRUSHING TEETH				<input type="checkbox"/> UNDERSTANDS SPEECH		<input type="checkbox"/> CONFUSED	<input type="checkbox"/> SUNDOWNER
	SHAVING				<input type="checkbox"/> UNDERSTANDS ENGLISH		<input type="checkbox"/> WITHDRAWN	<input type="checkbox"/> DIFFICULTY SLEEPING
	TOILET				<input type="checkbox"/> IF NO, SPECIFY LANGUAGE		ELIMINATION	
	COMMUNE				<input type="checkbox"/> READS		<input type="checkbox"/> OSTOMY	INCONTINENCE
	BEDPAN / URINAL				<input type="checkbox"/> OTHER		CATHETER (URINARY)	<input type="checkbox"/> BLADDER <input type="checkbox"/> BOWEL
	RX ADMIN						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:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> NO PROBLEMS NOTED | <input type="checkbox"/> COOPERATIVE | <input type="checkbox"/> DEPRESSED / WITHDRAWN | <input type="checkbox"/> ANGRY / HOSTILE |
| <input type="checkbox"/> REPORTS MOOD SWINGS | <input type="checkbox"/> SLEEP DISTURBANCE | <input type="checkbox"/> AGITATED | <input type="checkbox"/> ANXIOUS |
| <input type="checkbox"/> FLAT AFFECT | <input type="checkbox"/> 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	<input type="checkbox"/> WITH PATIENT	EYESIGHT: <input type="checkbox"/> CONTACT LENS <input type="checkbox"/> EYEGLASSES
	<input type="checkbox"/> TO FAMILY	DENTURES: <input type="checkbox"/> FULL <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER
		ASSISTIVE DEVICE:
		HEARING AID: <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT
		PROSTHESIS (Type):

- | | |
|---|---|
| <input type="checkbox"/> CODE STATUS: | <input type="checkbox"/> SENT WITH PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> ADVANCED DIRECTIVES <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> STS <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE |
| <input type="checkbox"/> COPY OF MOST RECENT EKG SENT WITH PATIENT | |
| <input type="checkbox"/> TB <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE | |

PRINTED NAME: _____	SIGNATURE _____	PHONE: _____	DATE: _____
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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.

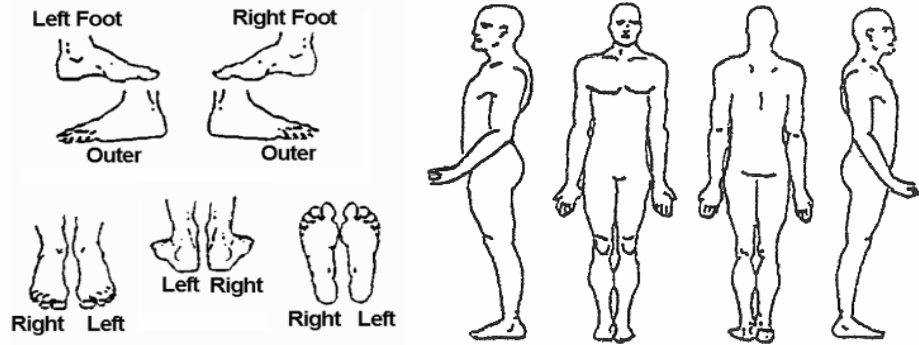
STAGE II: PARTIAL THICKNESS SKIN LOSS INVOLVING EPIDERMIS, DERMIS, OR BOTH.

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., TENDON 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 **D** = ALGINATES **G** = SILVADENE CREAM
- B** = TRANSPARENT FILM **E** = HYDROGEL **H** = NSS W / D
- C** = HYDROCOILOID **F** = FOAMS **I** = OTHER