PATIENT TRANSFER FORM

HOSPITAL

(INTER-AGENCY REFERRAL)

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX ☐M ☐F	3. HEALTH INSURANCE CLAIM NUMBER

4. PATIENT'S ADDRESS *(Street Number, City, State, Zip Code)*	5. DATE OF BIRTH	RELIGION

7. DATE OF THIS TRANSFER	8. FACILITY NAME AND ADDRESS TRANSFERRING TO	10. PHYSICIAN IN CHARGE AT TIME OF TRANSFER
		Will this physician care for patient after admission to new facility? ☐ YES ☐ NO

11. DATES OF STAY AT FACILITY TRANSFERRING FROM	14. PAYMENT SOURCE FOR CHARGES TO PATIENT		
ADMISSION DISCHARGE	A. ☐ SELF OR FAMILY	C. ☐ BLUE CROSS/ BLUE SHIELD	E. ☐ PUBLIC AGENCY *(Give name)*
	B. ☐ PRIVATE INSURANCE	D. ☐ EMPLOYER OR UNION	F. ☐ OTHER *(Explain)*

12A. NAME AND ADDRESS OF FACILITY TRANSFERRING FROM	12B. NAME AND ADDRESS OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH PATIENT WAS DISCHARGED IN PAST 60 DAYS.

CLINIC APPOINTMENT DATE TIME ATTACH CLINIC APPOINTMENT CARD	DATE OF LAST PHYSICAL EXAMINATION

RELATIVE OR GUARDIAN; Name. Address Phone Number

16. DIAGNOSES AT TIME OF TRANSFER — EMPLOYMENT RELATED A. ☐ YES B. ☐ NO

(a) Primary

(b) Secondary

(Check if present)

Disabilities
- Amputation
- Paralysis
- Contracture
- Decub. Ulcer

Impairments
- Mentality
- Speech
- Hearing
- Vision
- Sensation

Incontinence
- Bladder
- Bowel
- Saliva

Activity Tolerance Limitations
- None
- Moderate
- Severe

Patient knows diagnosis?

IMPORTANT MEDICAL INFORMATION

(State allergies if any)

DIET, DRUGS, AND OTHER THERAPY

at Time of Discharge

(Physician, please sign below)

Chest X-ray	date _____	result _____
C.B.C.	date _____	result _____
Serology	date _____	result _____
Urinalysis	date _____	result _____

SUGGESTIONS FOR ACTIVE CARE

BED

Position in good body alignment and change position every _____ hrs.

Avoid _____ position

Prone position _____ times/day as tolerated.

SIT IN CHAIR

_____ hrs. _____ times/day.

WEIGHT BEARING

Full _____ Partial _____ None _____

on _____ leg

LOCOMOTION

Walk _____ times/day.

EXERCISES

Range of motion _____ times/ day to _____

by patient _____ nurse _____ family _____

Other as outlined below _____

Stand _____ Min. _____ times/day.

SOCIAL ACTIVITIES

Encourage group _____ individual _____

within _____ outside _____ home.

Transport: Ambulance _____ Car _____

Car for handicapped _____ Bus _____

Signature of Physician or Nurse _____ Date _____

III. PATIENT INFORMATION

SELF-CARE STATUS
(Check level of ability. Write S in space if needs supervision only. Draw line across if inapplicable)

	Independent	Needs Assistance	Unable To Do	
Bed Activity				Turns
				Sits
Personal Hygiene				Face, Hair Arms
				Trunk & Perineum
				Lower Extremities
				Bladder Program
				Bowel Program
Dressing				Upper Extremities
				Trunk
				Lower Extremities
				Appliance, Splint
Feeding				Feeding
Transfer				Sitting
				Standing
				Tub
				Toilet
Locomotion				Wheelchair
				Walking
				Stairs

BED Low___ Mattress: Firm___ Reg.___
Other_____
Side Rails: Yes___ No___

BEHAVIOR
Alcoholic___ Belligerent___ Noisy___
Senile___ Suspicious___ Withdrawn___

MENTAL STATUS
Alert___ Forgetful___ Confused___

PAIN
Severity on D/C (0-10):_____
Location:_____

COMMUNICATION ABILITY	Yes	No
Can speak	___	___
Can write	___	___
Understands speaking	___	___
Understands writing	___	___
Understands gestures	___	___
Unerstands English	___	___

If no, state language spoken:_____

DIET
Regular___ Low Salt___ Diabetic___
Bland___ Low Residue___
Other_____
Feeds self___ Needs help___
Part___ All___

PATIENT USES
Appliance____ Catheter____
Colostomy____ Cane____ Crutches____
Prosthesis____ Walker____ Chair____

OTHER EQUIPMENT
_____
_____

ADDITIONAL PERTINENT INFORMATION
(Explain necessary details of care, diagnosis, medicalton, treatments, prognosis, teaching, habits, preference, etc. Therapists and social workers add signature and title to notes.)

IV. SOCIAL INFORMATION
(Adjustment to disability, emotional support from family, motivation for self care, socializing ability, financial plan, family health problem, etc.)

Social Welfare Agencies Active:_____ Signature:_____ Title:_____ Date_____