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 ADMISSION DISCHARGE	14. PAYMENT SOURCE FOR CHARGES TO PATIENT A. ☐ SELF OR FAMILY B. ☐ PRIVATE INSURANCE C. ☐ BLUE CROSS/ BLUE SHIELD D. ☐ EMPLOYER OR UNION E. ☐ PUBLIC AGENCY *(Give name)* 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 (a) Primary (b) Secondary			EMPLOYMENT RELATED A. ☐ YES B. ☐ NO	

(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 _____