Continuity of Care  Acute Care Transfer Form

Use this form for urgent/unplanned transfers for acute care.

End of life care/Code Status/Advance care planning (Check all that apply and include copies of each document.)

- None
- MOLST
- Durable power of attorney
- Living will
- DNR

List of diagnoses

Vital signs

BP:                             HR:                             RR:                             Temp:                             pOx:                             Glucose:                             Time taken:          am/pm

Allergies:                                                         Influenza (date):                                                   Pneumococcal (date):                                           Tdap/Td (date):

Facility information

Sent to:

Sent from:

Date:                           Unit:

Facility contacts

Name:                             Title:

Name:                             Title:

Phone: (   ) -                      Pager: (   ) -

Treating Provider (at transferring facility)

Name:                             MD  DO  NP  PA

Phone: (   ) -                      Pager: (   ) -

Patient pyschiatric status

- Voluntary
- Involuntary
- Conservatorship
- Constant observation

Reason for transfer (see Situation Background Assessment Recommendation form for more details)

Baseline cognition

Alert:                             Yes  No
Oriented X3:                       Yes  No
Follow simple instructions        Yes  No

Devices/special treatments

- Foley catheter
- Internal defibrillator
- IV/PICC line
- Pacemaker
- ITPN
- Other

Baseline pain

0 1 2 3 4 5 6 7 8 9 10

No pain    Mild    Moderate    Severe    Worst pain

Baseline ambulation

- Independent
- With assistive device
- With assistance
- Not ambulatory

Risk alerts

- None
- Falls
- Seizure
- Aspiration
- Elopedement
- Meds (see list)
- Harm to self
- Harm to others
- Restraints
- Other:

Baseline ambulation

- Limited/non-weight bearing
- Left
- Right

Isolation/precaution (currently)

- C-Diff
- MRSA
- TB
- ESBL
- CRE
- VRE

Site:

Comment:

Attached documentation and personal belongings: Shaded items required. Others provided if relevant. (Check all that apply)

- Face sheet
- Current medications list or MAR
- Wound care sheet
- Bed hold policy
- Recent H&P
- SBAR/Nurse progress notes
- Relevant orders
- Relevant labs
- Relevant X-rays
- Other
- Glasses
- Contacts
- Hearing device: R / L
- Walker
- Cane
- Dentures: U / L / Partial
- Prosthetic:
Continuity of Care **Acute Care Transfer Form**

Use this form when transferring patient back to facility.

<table>
<thead>
<tr>
<th>Form completed by: Name:</th>
<th>Title:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report called in by: Name:</td>
<td>Title:</td>
<td>Report called in to: Name:</td>
</tr>
</tbody>
</table>

**Consultation notes** (consulting provider to complete and return with patient for facility or agency)

continue on attachment if needed

**Expectations for situation:**
- [ ] Long-term problem
- [ ] Short-term problem

**List of relevant diagnoses:**

**Vital signs**

<table>
<thead>
<tr>
<th>BP:</th>
<th>HR:</th>
<th>RR:</th>
<th>Temp:</th>
<th>pO2:</th>
<th>Glucose:</th>
<th>Time taken:</th>
<th>am/pm</th>
</tr>
</thead>
</table>

**Recommendations/orders for the medical necessity of continuance of professional care as specified**

**Documents attached:**
- [ ] Additional notes and diagnoses
- [ ] New test results
- [ ] New prescription(s)/orders

- [ ] Skilled nursing care
- [ ] Respiratory therapy
- [ ] Occupational therapy
- [ ] Physical therapy
- [ ] Speech therapy

Follow-up visit required:
- [ ] Yes
- [ ] No

Appointment date:

Time:

**Consulting provider**

Name:

[ ] MD
[ ] DO
[ ] Other

Signature:

Date:

Phone: (   ) -

Pager: (   ) -

**Attached documentation and personal belongings:** Shaded items required. Others provided if relevant. *(Check all that apply)*

- [ ] Current medications list or MAR
- [ ] Wound care sheet
- [ ] Recent H&P
- [ ] SBAR/Nurse progress notes
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