



**Guidelines for Use of Post Acute Care to Emergency
Department/Hospital Transfer Form**
(Provided by the Akron Regional Hospital Association)

Objectives:

1. To enhance patient safety through standardized communication and identification process.
2. To provide a comprehensive assessment tool in the Post Acute Care setting to complete that would aid in the safe transfer of a patient from a non-acute to (acute) Emergency Department/ Hospital.
3. Provide a thorough assessment of patients with change in condition that can be communicated by phone/fax to covering physician.
4. To facilitate a comprehensive transition throughout the continuum of care.

Goal: Information provided through use of this tool would provide a more comprehensive assessment and improved communication of the patient's condition to the receiving hospital and has the potential for decreased assessment time at the receiving facility and a safer transition through the continuum of care.

Procedure:

1. The nurse or designee will complete the Post Acute Care to Emergency Department/Hospital Transfer Form on all patients who need to be transferred to the Emergency Department. ***All persons arriving at either facility will be expected to have this form with them.***
2. Fill in each section of the form (legible writing please) as to the persons condition and needs. Some shaded areas may be filled out ahead of time with the form being placed in the back of the patient's chart for ease during immediate need as well as copies of Advance Directives. This form is to be printed on pink paper for immediate identification in the facility. Please remember to make a copy for your own records and you may wish to make a copy for the EMS transferring crew.

3. Most sections are self explanatory however to alleviate any questions, please see the following:

- **Name of Facility:** *This is your facility name*
- **Phone Number:** *This is your phone number*
- **Resident's Primary Hospital:** *Name of hospital where resident generally receives care when needed*
- **Date of transfer:** *Date you are sending resident to hospital*
- **Time of transfer:** *Time you are sending resident to hospital (approximately)*
- **Transport Via:** *Mark in block provided whether resident is going by Ambulance or Other (ie: private car or 911 Squad) feel free to write in space if desire*
- **Name of person sending resident to hospital:** *Name of the nurse or person with whom the hospital staff may contact if there is additional questions that need answered*
- **Level:** *Level of care the resident is receiving at the time of discharge. If they are receiving Hospice care, please list the name of the Hospice.*
- **Resident's Name:** *Residents name*
- **Sex/DOB:** *Mark in box appropriate gender and list out date of birth(ie: 9/4/1929)*
- **Religion/Primary Language:** *List religion and primary language of resident*
- **Primary Contact:** *List name of resident's primary contact/responsible party and the relationship to patient. Mark in box if appropriate:
DPOA/HC-Durable Power of Attorney/Health Care
POA-Power of Attorney
Legal Guardian*
- **Notified:** *Mark in box if Primary Contact has been notified of need for transfer*
- **Chief Complaint:** *List the current problem/s the resident is experiencing (ie: chest pain, N/V, pain down L arm)*
- **Past Medical History:** *List any pertinent medical history that might be related to Chief Complaint (ie: MI and Pacemaker implanted 2/10/2006, IDDM, Glaucoma) Please send a copy of current Diagnosis List as often these are too long to include all in this section*

- **Influenza Vaccinations/Pneumo Vaccinations:** *Mark box date received (Due to regulations all receiving facilities must track dates and whether residents have received their vaccinations, please try to have this information readily available either in the front of your chart, on face sheet, or in a section for vaccinations.*
- **Wounds:** *Mark box if resident has any wounds, list the site(s) and if time permits include measurements of each*
- **Primary Diagnosis:** *List resident's Primary Diagnosis (ie: Alzheimer's)*
- **Date of Onset:** *Date of onset of Chief Complaint*
- **Time of Onset:** *Time of onset of Chief Complaint – approximate*
- **Vital Signs at time of transfer:** *fill in blanks for basic vital signs. List oxygen usage/liter flow if resident is usually on oxygen.*
- **Mental Status:** *Fill in boxes as appropriate for residents baseline*
How best to approach –if you have a best practice or know what works best (ie; nickname or only walk in front of person, hold their hand, etc., please share this information)
- **Advance Directive Sent:** *fill in this box and **please ensure a copy is sent with the resident***
- **DNR:** *fill in appropriate box*
 - DNR Status: *fill in appropriate box*
 - Full Code: *mark box if appropriate*
 - No transfusions or other: *Fill in if appropriate along with any other specific instructions*
 - Other: *Make any notations of any specifics regarding Advance Directives you may be aware of here*
- **Copy of MAR** with current medications/Lab or other Tests ordered: *Mark appropriate boxes and send copies as requested*
- **Name of MD/NP/PA who made decision to send patient/phone number/beeper:** *Name of MD/NP/PA and their phone numbers*
- **Attending Physician/Specialists:** *List of Physicians who should be consulted or contacted by receiving facility regarding their patient's condition*

- **Disabilities/Incontinence/Impairment/Functional Status/Indep./Assist/ Depend:** *Mark appropriate boxes for the areas under each category which is normal for your resident*
- **Infection:** *Mark appropriate boxes if currently infected and site for each*
- **Allergies:** *List any allergies (ie: sulfa, PCN, latex, etc)*
- **Diet:** *Fill in what their normal diet is (ie: regular, Regular NCS, NCC)*
- **To Be Referred to:** *List who or where resident to be seen by or info referred to at hospital/facility (ie: Hospitalist Physician or Dr. John Doe)*
- **Resident Uses:** *Mark all boxes that apply normally for the resident*
- **Items sent with Resident:** *Mark all boxes that apply and list additional items as necessary sent with resident*
- **Copy and send in the order listed:** *Copy and check off all items being sent with the resident, please send all of this information as appropriate to aid in the continuum of care and safety of your resident*
- **Please place ID armband on patient before transfer:** *You will be asked to place an ID armband on your resident prior to transport. This is a necessary safety precaution and you –the transferring facility staff member are verifying who this person is prior to transfer. These ID armbands are to have the resident’s full name listed on them prior to placing on the resident.*

**Resident/patient has been used interchangeably for this form and instructions*

This form is to be printed on pink paper and it is recommended that you keep a copy of the completed form prior to transfer from your facility.