PRINT THIS FORM ON PINK PAPER

AKRON REGIONAL HOSPITAL ASSOCIATION

POST ACUTE CARE TO EMERGENCY DEPARTMENT/ HOSPITAL TRANSFER FORM

Name of Facility: _____

Phone Number: _____

Resident's Primary Hospital: _____

Date of Transfer	Time of Transfer	Transport Via: ☐ Ambulance ☐ Other	Name of person sending resident to hospital:
_____	_____		_____

Level:
☐ Independent Living ☐ Skilled Acute ☐ Hospice Name of Hospice _____
☐ Assisted Living ☐ Long term Acute ☐ Other
☐ Intermediate ☐ Rehab

Resident's Last Name	**First Name**	**MI**	**Sex:** ☐ **M** ☐ **F**	Religion _____
			DOB: _____	Primary Language _____

Primary Contact _____ ☐ DPOA/HC ☐ POA ☐ Legal Guardian — Notified? ☐ Yes ☐ No

Relationship to Patient _____

CHIEF COMPLAINT

Past Medical History:

Influenza Vaccinations ☐ Yes ☐ No Date _____
Pneumo Vaccinations ☐ Yes ☐ No Date _____
☐ Wound/S Site/S _____

Primary Diagnosis

Date of Onset ___/___/___
Time of Onset _____ ☐ am ☐ pm

Vital signs at time of transfer
T: _____ P _____ ☐ O_2
R: _____ B/P _____ LITER FLOW: _____

Mental Status Baseline: ☐ Alert ☐ Oriented ☐ Aggressive ☐ Elopement Risk ☐ Secured Unit ☐ Confused
How to best Approach: _____

Advance Directive Sent: ☐ Yes ☐ No
Copy must be sent

DNR: ☐ Yes ☐ No
DNR Status: ☐ CC ☐ CC Arrest
☐ Full Code
☐ No Transfusions or other _____
☐ Other _____

Copy of MAR with current medications (within the last 24 hrs) ☐ Yes ☐ No (List & attach current medications)
Lab or other Tests ordered (to assist with baseline) ☐ Yes (send copy of results) ☐ No

Name of MD/NP/PA who made decision to send patient: _____
Beeper: _____ Phone: _____

Attending Physician: _____
Specialists: _____

Disabilities	Incontinence	Impairment	Functional Status	Indep.	Assist.	Depend
☐ Amputation	☐ Bladder	☐ Speech	Feeding:	☐	☐	☐
☐ Paralysis	☐ Bowel	☐ Hearing	Transfer:	☐	☐	☐
☐ Contracture	☐ Saliva	☐ Vision	Ambulation:	☐	☐	☐

Infection: ☐ TB ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL

Allergies:

Diet:

To Be Referred to (i.e. hospital or doctor):

Resident Uses:
☐ Glasses ☐ Cane ☐ Feeding tube ☐ Ostomy
☐ Hearing Aid ☐ Crutches ☐ Foley Cath ☐ Implant Defib
☐ Dentures ☐ Walker ☐ Tracheostomy ☐ Pacemaker
☐ Other: _____

Items Sent with Resident:
☐ Glasses ☐ Cane Prothesis:
☐ Hearing Aid ☐ Crutches ☐ Left
☐ Dentures ☐ Walker ☐ Right
☐ Other: _____

Copy and send in the order listed:
☐ Face Sheet ☐ Current DX List ☐ Recent Labs
☐ Medication Record ☐ Current Orders w/ new phone orders ☐ Progress Notes
☐ Treatment Record ☐ Current X-Ray Reports ☐ Advance Directives

NURSING HOME: PLEASE PLACE I.D. ARMBAND ON PATIENT BEFORE TRANSFER