Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Received Patient Transfer Form Tracking Tool

Instructions:

1. Data should be reported every time a patient is **received** from a sending location.
2. Instructions for completing the attached Tracking Tool:
    a. **Fill in your provider name at the top of the page.**
    Note: The column headings refer to various aspects of the information received from the sending provider.
    b. **Fill in each row (one row per patient) as a transfer occurs:**
        i. ***Date of transition.***
        Date transition occurred.
        ii. ***Provider type and where the patient is from.***
        Check one of the boxes provided, then fill in the name of the provider.
        iii. ***Was a standardized written transfer document used?***
        Check either "yes" or "no" based on whether or not information was received on a standardized transfer form (This form should contain standard data elements across organizations, with only slight differences.)
        iv. ***Was transfer information provided verbally?***
        If there was a conversation with the sending organization to relay transfer information, check "yes." If no verbal communication or only minimal information was provided verbally, check "no."
        v. ***Did you receive complete information?***
        Check "yes" or "no," based on whether or not you feel that adequate information was received to treat the patient.
        vi. ***If no, what did you need to TREAT the patient that you did not receive?***
        Check one of the boxes provided. If other, specify the information not provided
        vii. ***Did you receive contact information?***
        Check "yes" or "no" if you received the name and telephone number of the person to contact with questions.
        viii. ***If initial information was not complete, were you able to get complete information?***
        Check "yes" or "no" based on whether or not you were then able to obtain the information needed from the receiving provider.
3. Be sure to save your data every time, and to keep a copy of all completed transfer forms. The Transfer Communication Data Collection Tool may be used to aggregate and trend results. Please contact an Ohio KePRO Quality Improvement Specialist for more information.

OHIO KePRO
Ohio's Medicare Quality Improvement Organization
Clinically driven. Client focused. Value based.

Organization Name:								
Date of Transition (xx/xx/xxxx)	**Provider type and where patient is from**	**Was a standardized written transfer document used?**	**Was transfer information provided verbally?**	**Did you receive complete information?**	**If no, what did you need to TREAT the patient that you did not receive?**		**Did you receive contact information?**	**If initial information was not complete, were you able to get complete information?**
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information	□ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information	□ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information	□ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information	□ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No

Organization Name:							
Date of Transition	**Provider type and where patient is from**	**Was a standardized written transfer document used?**	**Was transfer information provided verbally?**	**Did you receive complete information?**	**If no, what did you need to TREAT the patient that you did not receive?**	**Did you receive contact information?**	**If initial information was not complete, were you able to get complete information?**
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information □ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information □ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information □ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No
	□ Hospital Inpatient □ ED □ Nursing Home □ Home Health □ Assisted Living □ Long-Term Acute Care Name: ______________	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Medication Information □ Discharge Instructions □ Orders for Post-Acute Services □ Procedure/Test Information □ In-Hospital Treatment Information □ Diagnosis Information □ Therapy Notes □ History and Physical □ Lab Results □ Other: ____________ ____________________ ____________________	□ Yes □ No	□ Yes □ No