PATIENT HANDOFF/ TRANSFER FORM

INSERT INSTITUTION LOGO

DATE OF TRANSFER: ______/______/______

TIME OF TRANSFER: ______ : ______ AM PM

PATIENT INFORMATION

Last Name *First Name* *MI*

Street Address *City*

State/Province *Zip/Postal Code*

___/___/___
DOB

GENDER: M F

CONTACT PERSON/LEGAL GUARDIAN/DPOA

Last Name *First Name*

( )
Emergency Telephone

NOTIFIED *Yes* *No*

Street, City, State/Province, Zip/Postal Code

Relationship to Patient

NAME OF FACILITY TRANSFERRING FROM

Facility Name *Address* *City* *State/Province* *Zip/Postal Code*

NAME OF RN/LPN/MD *in Charge of Patient at Time of Transfer*

( )
Telephone

REASON FOR TRANSFER

PRIMARY DIAGNOSIS

SECONDARY DIAGNOSIS

CODE STATUS
Copy of signed DNR Must Be Sent

DNR: ☐ Yes ☐ No **DNR Status:** ☐ CC ☐ CC Arrest **Full Code:** ☐ Yes ☐ No

ACUTE CHANGES FROM BASELINE ASSOCIATED WITH TRANSFER

VITAL SIGNS AT TRANSFER – TIME TAKEN: _____ : _____ **AM PM**

BP: /	TEMP:	PULSE:	RESP:	SAO_2: ☐ O_2 Therapy

IMMUNIZATION STATUS ☐ *Attached*

T.S.T. (PPD)	Date:	Results:		
Influenza	Date:	☐ UNK		
Pneumococcal	Date:	☐ UNK		
Meningococcal	Date:	☐ UNK		
D.T.P.	Date:	☐ UNK		
Tetanus	Date:	☐ UNK		

Hepatitis A:	Date:	☐ UNK
Hepatitis B:	Date:	☐ UNK
Measles, Mumps, Rubella	Date:	☐ UNK
Varicella	Date:	☐ UNK
Inactivated Poliovirus	Date:	☐ UNK

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AT RISK ALERTS

☐ Fall
☐ Harm to Self
☐ Seizure
☐ Harm to Others (assaultive)
☐ Elopement
☐ Aspiration
☐ Impaired Safety Awareness
☐ Restraints
☐ Skin Failure (Breakdown)
Braden Score:
☐ Other

TREATMENT RECEIVED WITHIN LAST 14 DAYS

☐ Chemotherapy
☐ Dialysis
☐ IV Medication
☐ Oxygen Therapy
☐ Transfusions
☐ Radiation Therapy
☐ Ventilator
☐ Tracheotomy Care
☐ Suctioning

IMPAIRMENT

☐ Mental
☐ Speech
☐ Hearing
☐ Vision
☐ Sensation

DISABILITIES

☐ Amputation
☐ Prosthesis
☐ Paralysis
☐ Paresis
☐ Contractures

SAFETY

☐ Restraints
☐ Sitter
☐ Wanders
☐ Siderails
☐ High Risk for Falls

INCONTINENCE

☐ Bladder
☐ Bowel
☐ Saliva

PATIENT USES

☐ Feeding Tube
☐ Foley Catheter
☐ Tracheotomy
☐ Central Line
☐ Ostomy
☐ Implant Defib
☐ Pacemaker

DECISION MAKING

☐ Independent
☐ Moderately Impaired
☐ Severely Impaired

ITEMS SENT WITH PATIENT *(Assistive Devices)*

☐ Glasses
☐ Hearing Aid
☐ Dentures
☐ Cane
☐ Crutches
☐ Walker
☐ Prosthesis: Left Right
☐ Other:

DIET

Type of Diet:	☐ Regular	☐ Mechanical Soft	☐ Thickened Liquid	☐ Other:
Diet Restrictions:	☐ Cardiac	☐ Renal	☐ Diabetic	☐ Other:
Feeding Requirement:	☐ Independent	☐ Needs Assistance	☐ Dependent	☐ Tube Feed

SPECIAL CARE ORDERS

☐ Enemas PRN
☐ O_2 .... Liter Flow: __________
☐ IV Care/PICC .... Date: / / Length: ______ Site: ______ Verified by X-ray: ☐ Yes ☐ No
☐ Wound Care/ Dressing Changes:
☐ Suction
☐ Respiratory Care
☐ Ventilator/Settings TV: _______ PEEP: _______ PCO_2: _______ SAO_2: _______ SIMV: _____
☐ Additional Orders *(Includes tubes, Foleys, IVs)*:

LAB WORK

THERAPIES

☐ PT
☐ OT
☐ ST