TRANSFER DOCUMENT CHECK LIST - HOME HEALTH TO HOSPITAL

Hospital Fax #: ___________________________ Page ___ of ___

Resident/Patient Name ___________________________ Date: ___________________________

Educate patients/families/care givers that these documents/items should ALWAYS accompany them to the hospital:

☐ Current medication list or medications
☐ Advanced directives  ☐ Not Applicable
☐ POLST or care limiting orders  ☐ Not Applicable
☐ Current physician orders
☐ Surgical Report

These documents should be faxed by Home Care Agency when aware of transfer if Indicated/AVAILABLE:

☐ SBAR (Situation-Background-Assessment-Recommendations) /Nurses progress notes
☐ Plan of Care of most recent treatment order (e.g. wound care with last measurements)
☐ Patient face sheet
☐ Transfer Oasis
☐ Wound care notes
☐ Prior Hospitalizations within past 3 months:
  (Facility Names) ___________________________ ___________________________
  ___________________________ ___________________________

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## Transfer Summary Form – Home Care to Hospital

**Name (first, middle initial, last)**

<table>
<thead>
<tr>
<th>Language spoken:</th>
<th>English</th>
<th>Spanish</th>
<th>Armenian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Korean</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Written language:</th>
<th>English</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Korean</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of birth:**

**Treating physician in current setting:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

**If additional information needed contact:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
</tr>
</thead>
</table>

**Date of most recent test:**

**Reason for Emergency Care/Hospitalization:**

- [ ] Improper medication administration
- [ ] Injury caused by fall
- [ ] Respiratory infection
- [ ] Other respiratory problem
- [ ] Heart failure
- [ ] Cardiac dysrhythmia
- [ ] MI or chest pain
- [ ] Other heart disease
- [ ] CVA/TIA
- [ ] Hypo/hyperglycemia
- [ ] (diabetes out of control)
- [ ] GI bleeding/obstruction/impaction
- [ ] Dehydration, malnutrition
- [ ] UTI
- [ ] IV cath-related infection
- [ ] Uncontrolled pain
- [ ] Acute mental/behavioral health problem
- [ ] DVT, PE
- [ ] Other: ________________
- [ ] Unknown reason

**Therapies Provided in Home**

- [ ] RN
- [ ] PT
- [ ] OT
- [ ] ST
- [ ] Social Services
- [ ] Other: ________________

**Known Diagnoses:**

**Known allergies:**

**Recent Clinical Information / Pain Management History**

<table>
<thead>
<tr>
<th>BP</th>
<th>T</th>
<th>P</th>
<th>R</th>
<th>pO2</th>
<th>Last pain assessment score (0-10):</th>
<th>Pain medication used:</th>
</tr>
</thead>
</table>

**Current Mental Status**

- [ ] Oriented
- [ ] Disoriented
- [ ] Comatose
- [ ] Lethargic
- [ ] Forgetful
- [ ] Agitated
- [ ] Depressed
- [ ] Other: ________________
- (e.g. aggressive, disruptive)

**At Risk Alerts**

- [ ] Wanders
- [ ] Fall risk
- [ ] Seizure precautions
- [ ] High risk for re-hospitalization
- [ ] Other: ________________

**Immunizations/Testing (if known)**

- [ ] Influenza (date): __________
- [ ] Pneumococcal (date): __________
- [ ] Tetanus (date): __________
- [ ] TB (date): __________
- [ ] Positive
- [ ] Negative
- [ ] Skin test
- [ ] Chest X-ray

**Skin/Wound Care**

- [ ] High risk for pressure ulcer
- [ ] Current pressure ulcer/s or wounds:

<table>
<thead>
<tr>
<th>Location/s:</th>
<th>Site/s:</th>
</tr>
</thead>
</table>

**Lines/Devices**

- [ ] IV
- [ ] PICC
- [ ] Pacemaker
- [ ] AICD
- [ ] Foley Catheter
- [ ] Dialysis Catheter
- [ ] Feeding tube Specify: [ ] PEG [ ] J tube [ ] G tube
- [ ] BCAP
- [ ] CPAP
- [ ] NG tube

**Known Communicable Illnesses**

- [ ] MRSA
- [ ] VRE
- [ ] C-Diff
- [ ] Other: ________________

**Form Completed By (print)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Contact #</th>
</tr>
</thead>
</table>

6/12