Kentucky Health Care Provider Adult Transfer Form

FROM			TO	
Facility/Agency Address			Facility/Agency	
			Address	
			City	State
			Phone ( ) -	Fax ( ) -
Transferring Physician.	Phone: ( ) -		Receiving Physician	Phone ( )
Date of Admission	Date of Discharge		Report called to:	
Transfer Mode:	Private Auto ☐	Ambulance ☐	Public Transportation ☐	Public Air ☐	Medical Air ☐

Patient Information

Name			Health Care Decision Maker (name): Notified of transfer: no ☐ yes ☐ Date notified:		
Address			Relationship to patient:	Phone number:( ) -	
City	State	Phone ( ) -	Alternate Address (For home care provided at address other than home)		
Gender: Male ☐ Female ☐	Marital Status:		City	State	Phone: ( ) -
Date of Birth / /	Social Security # - -		Home Caregiver Name	Home Caregiver Phone: ( ) -	

Insurance or Payor Information

Primary:		Secondary:		Other:	
ID #	Group #	ID #	Group #	ID #	Group #
Precert./Case Manager Phone: ( ) -		Precert./Case Manager Phone: ( ) -		Precert./Case Manager Phone: ( ) -	

Advance Directives/POA/Guardian (*Attach copies to transfer form)

☐ Durable Power of Attorney *	Name:	Telephone: ( ) -
☐ Power of Attorney	Name:	Telephone: ( ) -
☐ Guardianship	Name:	Telephone: ( ) -
☐ Living Will *	☐ None	☐ Unknown

Transfer Information

Records Sent With Patient

☐ Admission history & physical	☐ PT/OT/ST/RT eval./notes	☐ Current med. list	☐ Current labs
☐ X-ray and diagnostic reports	☐ Physician's orders/notes	☐ MD consult summary	☐ Operative report
☐ Copy of Advance Directives	☐ Recent progress notes	☐ Original EMS DNR	☐ Discharge summary
☐ Copy of this transfer form to EMS	Psychological Testing ☐	Psychiatric Evaluation ☐	

Current Vitals

Date and time taken:	BP	T	P	R	Weight: Date/Time	Height: Date/Time
Patient pain level (0-10):	Location(s) of pain:				Type and time of last pain med.:	

At Risk For

☐ Falls ☐ Skin breakdown ☐ Seizures ☐ Communicable disease ☐ Aspiration ☐ Other

Comments:

Form faxed to:	☐ HH	☐ NH	☐ Rehab	☐ Psych	☐ Hospital	☐ Correctional Facility	☐ Other:
Form faxed at: : a.m. or p.m.			**Form faxed by: (name & title)**				

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Current Health Status (To be completed by nurse)

Diagnoses (DX)

Current primary DX:

Current secondary DX:

Secondary DX:

Recent Surgery: **Date:**

Surgeon

Secondary DX:

Mental Status

Alert: ☐ Yes ☐ No | Oriented: ☐ Person ☐ Place ☐ Time

Non-Verbal: ☐ Yes ☐ No | Confused: ☐ Occasionally ☐ Always

Cooperative: ☐ Yes ☐ No | Other:

Speech ☐ WNL ☐ Impaired

☐ Speaks English ☐ Speaks: (specify)

Vision ☐ Normal | Glasses ☐ Contacts

☐ Aids Sent ☐ Blind | Comments:

Hearing ☐ Normal | Impaired ☐ Hearing Aid

☐ Aids Sent ☐ Deaf | Comments:

Bowel	**Bladder**
☐ Continent	☐ Continent
☐ Incontinent	☐ Incontinent
☐ Ostomy	☐ ____Catheter/ Changed:
Date of last BM: / /	Other:

Nutrition Dentures: ☐ No ☐ Yes ☐ Sent with Patient

Diet:

Supplements:

Tube Feeding:

IV Therapy Heparin Used: ☐ Yes ☐ No

☐ Peripheral ☐ Implanted Port ☐ Tunnelled CVC

☐ Midline ☐ PICC Sutured ☐ vs. Stat Lock ☐

Length of Catheter: | Arm circumference:

Other:

Respiratory ☐ WNL ☐ 02 LPM

Delivery device: ☐ Mask ☐ Cannula ☐ Other

☐ Trach size | Type

Infection Control TB: Date of last TB Skin Test: / /

mm Reactive:

Date of Chest X-ray: / /

MRSA status: ☐ Infection ☐ Colonization Site:

VRE status: ☐ Infection ☐ Colonization Site:

C-diff toxin: Date of Result:

Diarrhea present ☐ Yes (Isolation recommended) ☐ No

Other multi-drug resistant organism:

Allergies

Drug/herbal allergies:

Food allergies:

Latex Allergy: ☐ Yes ☐ No | Tape Allergy: ☐ Yes ☐ No

Immunizations: (Provide date of immunization or mark N/A)

Influenza:	Pneumonia:
Tetanus:	Rhogam:

Skin: ☐ Intact

Date of last dressing change: / / : am/pm

Ulcers: ☐ Pressure ☐ Stasis ☐ Diabetic ☐ Other

Location:	Stage:
Location:	Stage:
Location:	Stage:
Location:	Stage:
Location:	Stage:
Location:	Stage:
Location:	Stage:

Burns: ☐ Chemical ☐ Thermal ☐ Tape ☐ Other

Location	Stage:
Location:	Stage:

Other: ☐ Skin tears ☐ Bruising ☐ Rash

Location:	Stage:
Location:	Stage:

Surgical Incisions:

Location:	Stage:
Location:	Stage:

Functions of Daily Living

Status	Independent	Needs Help	Unable to Do
Walking	☐	☐	☐
Sitting	☐	☐	☐
Turn self in bed	☐	☐	☐
Bathing self	☐	☐	☐
Dressing self	☐	☐	☐
Feeding self	☐	☐	☐
Transfers	☐	☐	☐
Other:	☐	☐	☐

Equipment Needs

Status	PT HAS	Ordered	Not ordered	NA
W/C	☐	☐	☐	☐
Walker	☐	☐	☐	☐
Cane	☐	☐	☐	☐
Prosthesis	☐	☐	☐	☐
Mattress/press. relief	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Name of supplier: | Phone: ( ) -

Other Notes:

Completed by (print name): RN LPN (circle one)

Signature: **Date:**

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Discharge Physician's Orders	
Final Diagnoses	
Primary:	
All other Conditions:	
Orders on Transfer:	
Medications:	
Diet:	
Tube feedings:	Type of tube(s)
Therapies:	
Weight bearing status and restrictions:	
Follow-up:	
Physician signature	**Date:**