Assisted Living to Hospital Transfer Form

INTERACT® Assisted Living V 1.0 Tool

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

Language: ☐ English ☐ Other _____ Resident is: ☐ ALF ☐ Long-term

Date of move in *(most recent)* _____/_____/_____ DOB _____/_____/_____

Primary diagnosis(es) at time of move in _____

Sent To *(name of hospital)* _____

Date of transfer _____/_____/_____

Sent From *(name of ALF)* _____ Unit _____

Who to Call at the Assisted Living Facility to Get Questions Answered

Name / Title _____

Tel (_____) _____

Contact Person _____

Relationship *(check all that apply)*

☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other

Tel (_____) _____

Notified of transfer? ☐ Yes ☐ No

Aware of clinical situation? ☐ Yes ☐ No

Primary Care Clinician in Assisted Living Facility ☐ MD ☐ NP ☐ PA

Name _____

Tel (_____) _____

Code Status ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain

Key Clinical Information

Reason(s) for transfer _____

Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____

Relevant diagnoses ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ Ca *(active treatment)* ☐ Dementia ☐ Other _____

Vital Signs BP _____ HR _____ RR _____ Temp _____

Most recent pain level _____ (☐ N/A) Pain location: _____

Most recent pain med _____ Date given _____/_____/_____ Time *(am/pm)* _____

Usual Mental Status:

☐ Alert, oriented, follows instructions

☐ Alert, disoriented, but can follow simple instructions

☐ Alert, disoriented, but cannot follow simple instructions

☐ Not Alert

Usual Functional Status:

☐ Ambulates independently

☐ Ambulates with assistive device

☐ Ambulates only with human assistance

☐ Not ambulatory

Additional Clinical Information:

☐ SBAR Acute Change in Condition Note included

☐ Other clinical notes included

For residents with lacerations or wounds:

Date of last tetanus vaccination *(if known)* _____/_____/_____

Devices and Treatments

☐ O2 at _____ L/min by ☐ Nasal canula ☐ Mask (☐ Chronic ☐ New)

☐ Nebulizer therapy; (☐ Chronic ☐ New)

☐ CPAP ☐ BiPAP ☐ Pacemaker ☐ IV ☐ PICC line

☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator

☐ Enteral Feeding ☐ TPN ☐ Other _____

Isolation Precautions

☐ MRSA ☐ VRE

Site _____

☐ C. difficile ☐ Norovirus

☐ Respiratory virus or flu

☐ Other _____

Allergies

_____

_____

_____

_____

_____

Risk Alerts

☐ Anticoagulation ☐ Falls ☐ Pressure ulcer(s) ☐ Aspiration ☐ Seizures

☐ Harm to self or others ☐ Restraints ☐ Limited/non-weight bearing: (☐ Left ☐ Right)

☐ May attempt to exit ☐ Swallowing precautions ☐ Needs meds crushed

☐ Other _____

Personal Belongings Sent with Resident

☐ Eyeglasses ☐ Hearing Aid

☐ Dental Appliance ☐ Jewelry

☐ Other _____

_____

Assisted Living Facility Would be able to Accept Resident Back Under the Following Conditions

☐ ER determines diagnoses, and treatment can be done in ALF ☐ VS stabilized and follow up plan can be done in ALF

☐ Other _____

Additional Transfer Information on a Second Page:

☐ Included ☐ Will be sent later

Form Completed By *(name/title)* _____ **Signature** _____

Report Called in By *(name/title)* _____

Report Called in To *(name/title)* _____ Date _____/_____/_____ Time *(am/pm)* _____

Assisted Living to Hospital Transfer Form *(additional information)*

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Not critical for Emergency Room evaluation; may be forwarded later if unable to complete at time of transfer.

RECEIVER: PLEASE ENSURE THIS INFORMATION IS DELIVERED TO THE NURSE RESPONSIBLE FOR THIS PATIENT

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

DOB _____/_____/_____ Date transferred to hospital _____/_____/_____

Contact at Assisted Living Facility for Further Information

Name / Title _____

Tel (_____) _____

Social Worker

Name _____

Tel (_____) _____

Family and Other Social Issues *(include what hospital staff needs to know about family concerns)* _____

Behavioral Issues and Interventions

Primary Goals of Care at Time of Transfer

☐ Rehabilitation and/or Medical Therapy with intent of returning home

☐ Chronic long-term care

☐ Palliative or end-of-life care

☐ Receiving hospice care ☐ Other _____

Treatments and Frequency *(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN)*

Diet

Needs assistance with feeding? ☐ No ☐ Yes

Trouble swallowing? ☐ No ☐ Yes

Special consistency *(thickened liquids, crush meds, etc…)?* ☐ No ☐ Yes

Enteral tube feeding? ☐ No ☐ Yes *(formula/rate)* _____

Skin/Wound Care

Pressure Ulcers *(stage, location, appearance, treatments)*

Immunizations

Influenza:

Date _____/_____/_____

Pneumococcal:

Date _____/_____/_____

Physical Rehabilitation Therapy

Resident is receiving therapy with goal of returning home? ☐ No ☐ Yes

Physical Therapy: ☐ No ☐ Yes

Interventions _____

Occupational Therapy: ☐ No ☐ Yes

Interventions _____

Speech Therapy: ☐ No ☐ Yes

Interventions _____

ADLs Mark I = Independent D = Dependent A = Needs Assistance

Bathing _____ Dressing _____ Transfers _____

Toileting _____ Eating _____

☐ Can ambulate independently _____

☐ Assistive device *(if applicable)* _____

☐ Needs human assistance to ambulate _____

Impairments – General

☐ Cognitive ☐ Speech ☐ Hearing

☐ Vision ☐ Sensation

☐ Other _____

Impairments – Musculoskeletal

☐ Amputation ☐ Paralysis ☐ Contractures

☐ Other _____

Continence

☐ Bowel ☐ Bladder

Date of last BM _____/_____/_____

Additional Relevant Information _____

Form Completed By *(name/title)* _____

If this page sent after initial transfer: Date sent _____/_____/_____ Time *(am/pm)* _____

Signature _____