# Home Health to Hospital Transfer Form

INTERACT® Home Health V 1.0 Tool

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

Language: ☐ English ☐ Other _____ Patient is: ☐ SNF/rehab ☐ Long-term

Date SOC *(most recent)* _____/_____/_____ DOB _____/_____/_____

Primary diagnosis(es) at SOC_____

**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

**Sent To** *(name of hospital)* _____

Date of transfer _____/_____/_____

**Sent From** *(name of Home Health)*_____

**Who to Call at the Home Health to Get Questions Answered**

Name/Title _____

Tel (_____)_____

**Primary Care Clinician in Home Health** ☐ 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 _____ O2 Sat _____ Time taken *(am/pm)* _____

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 patients 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 Patient**

☐ Eyeglasses ☐ Hearing Aid

☐ Dental Appliance ☐ Jewelry

☐ Other _____

**Home Health Would be able to Accept Patient Back Under the Following Conditions**

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

☐ 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)*_____

# Home Health 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**

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

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

**Contact at Home Health 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**

Patient 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** _____