

Home Health to Hospital Transfer Form



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 _____

Sent To (name of hospital) _____
Date of transfer ____/____/____
Sent From (name of Home Health) _____

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

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)*



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 _____