

TRANSITIONING **TO:** Hospital; SNF; ICF; ICF/MR; Swing Bed; RCF/ALF; LTCH; _____
FROM: Hospital; SNF; ICF; ICF/MR; Swing Bed; RCF/ALF; LTCH; _____

Name: (Last) _____ (First) _____ (MI) _____ (DOB) _____ MRN: _____

Transferring Facility: _____ Transferred to: _____ Date: ___/___/___; Time: ___:___:___

Contact/Title: _____; Unit Phone: _____ Fax: _____

Reason for Transfer: Cardiac; Respiratory; GI; Psy; Fall/Fx; LOC Status Change; Other: _____

Current Vitals: BP _____; T _____; P _____; R _____; Pulse Ox _____; Time ___:___:___; Weight _____ lbs.; Height ___ ft. ___ inches.

Allergies: No Known; Yes. If "Yes" List All: _____

Transported by: EMS; Family; Care Facility; Verbal Report Given by: (print name/title) _____

Name of Healthcare Decision Maker and/or Local Contact to be Notified: _____, Phone: _____

Advance Directives: Yes; No. If "Yes" Indicate Type: Living Will; Power of Attorney; Special Power of Attorney; Sent with Person Yes; No

Able to Communicate: Yes; No. If "No" Explain: _____

Speaks English: Yes; No. If "No" Specify Native Language: _____

Religious/Cultural/Literacy/Other Issues: Yes; No. If "Yes" Please Identify: _____

Admission to Other Hospital/LTC Facility in Past 30 Days: None; Unknown; Yes. If "Yes" List: Reason, Date & Location of Previous Admission: _____

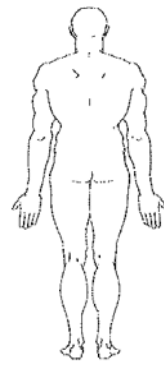
Skin Intact: Yes; No. If "No" Identify each non-intact area and drain with a number and describe site and care below:

#1 Site: _____
Care: _____

#2 Site: _____
Care: _____

#3 Site: _____
Care: _____

Other uncontained body fluids/drainage _____



CHECK ALL THAT APPLY:

Mental Status: Alert; Oriented; Non-Verbal; Unresponsive; Confused; Disruptive; Withdrawn; Depressed; Uncooperative;

Pain Assessment: None; Acute; Chronic; Intermittent; Sharp; Dull; Location: _____;

Intensity (1-10) _____; Time of Last Pain Med: _____;

Infection: No; Yes. If "Yes" Colonization (Carrier) No; Yes. If marked "Yes" to either Attach Appropriate Infection Form.

Fall History: No; Yes; If "Yes" Date: ___/___/___ Did Fall Result in Injury: Yes; No. If "Yes" Describe: _____

Bowel: Continent, Last BM ___/___/___; Involuntary; Diarrhea; Ostomy- Type: _____, Changed ___/___/___

Bladder: Continent; Incontinent; Catheter/Urostomy/Type _____, Inserted ___/___/___; Dsg Changed ___/___/___

IV: Type/location _____; IV Therapy: Medication- _____; Frequency _____; Last Dose Given ___/___/___; Next Dose Due ___/___/___

Assisted Devices: None; Cane; Walker; Wheelchair; Crutches; Other _____; Sent with Person Yes; No;

Appetite/Nutrition: Diet/Type: _____; Good; Fair; Feeding Tube Type _____; Inserted/Changed ___/___/___; Dentures Sent: Yes; No;

Safety Concerns: None; Aspiration; Skin Breakdown; Seizures; Isolation; Wander/Elope; High Risk for Falls; _____

Space intentionally left blank for facility identification

Most Recent Immunizations: None; Influenza ___/___/___; Pneumonia ___/___/___; Tetanus ___/___/___; TB Skin Test ___/___/___

Impairments: None;

- Mental: _____; Speech: _____;
- Hearing: _____ Hearing Aid Sent with Person Yes; No;
- Vision: _____ Glasses Sent with Person Yes; No;
- Sensation: _____
- Amputation: Yes; No. If "Yes" Does Person Have Prosthesis Yes; No. If "Yes" was Prosthesis Sent with Person Yes; No.
- Contracture: _____
- Paralysis: _____

Treatments Received Within Last 14 Days: - Date Administered:

- Chemotherapy _____/___/___
- Radiation _____/___/___
- * Oxygen Therapy _____/___/___
- * Tracheotomy Care _____/___/___
- * Ventilator _____/___/___
- Transfusion(s) _____/___/___
- * Dialysis _____/___/___
- Isolation / Infection _____/___/___
- * BiPap/CPAP _____/___/___
- Hospice Care _____/___/___
- * Suctioning; Type _____; Frequency _____/___/___
- None of the Above Treatments or Procedures Received

* Only complete for persons transferring to Skilled Nursing level of care. If dates are not recorded, the last 14 days of nurse notes and MARS must be sent to SNE

Activities of Daily Living:

	Independent	Needs Help	Not Able
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Treatment:

- Physical Therapy Frequency _____; Last Received: ___/___/___
- Occup Therapy Frequency _____; Last Received: ___/___/___
- Speech Therapy Frequency _____; Last Received: ___/___/___

The following items are REQUIRED to be sent with ALL patients on Day of Discharge:

- Face Sheet: _____ With payer sources Yes; No
- Medication Admin Record: _____ Send most current and complete MAR which includes IV, IM and PO medications and flushes, blood transfusions and chemotherapy. If person is transferring to SNE care and treatment dates are not recorded in the above section, send last 14 days of MAR. Yes; No
- H & P: _____ If older than 30 days, have physician review/update/sign/date* (*for LTC use only) Yes; No
- Physician Orders / Discharge Summary: _____ If not checked as "sent," Medical Records should send a copy to the receiving facility when completed. **Note to receiving facility:** If a Physician Discharge Summary is not received within 7 days, or to receive additional patient records, a request for information from the Medical Records department should be faxed to: _____ (fax number). Yes; No
- Nursing Assessment/Notes: _____ Send last 2 days if patient is transferring to SNE and treatment dates are not recorded in above section, send last 14 days of nursing notes. Yes; No
- Consult Reports _____ A copy of each consult Yes; No
- PT/OT/ST/Wound Therapy: _____ Evaluation & notes from the previous week Yes; No
- Physician Progress Notes: _____ Last 4 days Yes; No
- Pertinent Laboratory Results: _____ Include most recent UA, C&Ss, CBC, glucose, electrolytes, and labs used in dosing meds (ie. Theophylline, Dilantin levels, INRs, etc.) Yes; No
- Discharge Medication Reconciliation Record _____ Yes; No
- Adv. Directive-DPOA-Life w/ Dignity _____ Yes; No
- This Completed Form _____ Yes; No

Based upon post acute care facility's requirements, the following MAY need to be sent. Check with each facility PRIOR to discharge.

- Pertinent Radiology/Special Studies Reports: _____ Include swallowing studies, MRIs, CT Scans, ultrasounds, EKG, stress test, echo, etc. Yes; No
- Operative Reports: _____ For all major surgeries Yes; No
- Preadmission Screening & Annual Resident Review (PASARR): _____ Complete screening for patients who are suspected of having mental illness (MI), developmental disabilities/mental retardation (DD/MR), and/or related conditions and who are going to a Medicaid-certified LTC facility Yes; No

L.I.N.C. Form Completed By: _____ Date: _____

