FORM 9-2

Transfer Summary

(Transfer from Acute Hospital to SNF)

Patient Information

Patient name: _____

Birth date: _____ Age: _____ Sex: ☐ F ☐ M

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ SEP Religion: _____

Address: _____
(street) *(city)*

Phone: _____ _____
(home) *(work)*

Allergies: _____

Current medications (include date and time of last dose): _____

_____

Pain management therapies: _____

Hospital No.: _____

Admit Date: _____ Discharge Date: _____

Transported by: _____

Physician in charge at time of transfer or discharge: _____

Phone: _____

Will this physician continue to care for patient? ☐ Y ☐ N

If no, physician for continued care: _____

Transferred to or referred to: _____

Address: _____

Phone: _____

Transferred from: _____

Nursing Unit: _____ Phone No.: _____

Discharge Coordinator: _____

Name of nearest relative or friend: _____

Relationship: _____

Address: _____

Phone: _____ _____
(home) *(work)*

Notified of transfer: ☐ Y ☐ N

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Physician's Report

Primary diagnosis (onset): _____

_____

Secondary diagnosis (onset): _____

_____

Hospital course (include surgical procedures/dates): _____

_____

Reason for transfer: _____

Rehab potential: ☐ Good ☐ Fair ☐ Poor ☐ N/A

Patient knows diagnosis and prognosis: ☐ Yes ☐ No Advance Directive: ☐ Yes ☐ No

Physician Orders for Continued Care/Treatment Plan *(include medications, treatments, diet, activities and rehabilitation services to be taught)*: May Use Physician's Order Form.

_____

_____

_____

☐ PT ☐ OT ☐ ST Home Health F/U: ☐ Yes ☐ No Agency: _____

Physician Signature *(required)*: _____

Date: _____ Time: _____ AM / PM

Patient Assessment

Nursing to Complete

	Indep.	Assist	Unable		Usual	Occas.	Rarely
Bathes				Able to Communicate			
Dresses				Motivated to Self-Care			
Eats				Follows Directions			
Personal Hygiene				Bowel Control – Date of last BM __/__/__			
Transfers				Bladder Control – Date cath. inserted __/__/__			
Ambulates				☐ Restraints ☐ Fall Risk ☐ Wanders			

☐ Cane ☐ Crutch ☐ Walker ☐ Alert ☐ Confused ☐ Forgetful

Pressure Areas: ☐ Yes ☐ No Describe: _____

Decubitus Ulcers: ☐ Yes ☐ No Describe: _____

Skin Care Form Attached: ☐ Yes ☐ No

Language spoken/understood, if other than English: _____

Diet: _____ Time of previous meal: _____ AM / PM

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Other Information

Other Pertinent Information from Hospital Nurse *(Observations, Instructions Given, Continuing Teaching Needs, Unique Approaches Used, Goals)*: _____

_____

Name: _____

Signature: _____
(title)

Date: _____ Time: _____ AM / PM

Phone: _____

Other Pertinent Information from Therapists, Dieticians, Social Services, etc.: _____

_____

_____

Name: _____

Signature: _____
(title)

Date: _____ Time: _____ AM / PM

Phone: _____

Personal Belongings Transferred (dentures, hearing aid, glasses, money, prosthesis, jewelry, electronic devices, other valuables): _____

_____

Sent with Patient:

☐ X-rays ☐ H&P/Consults ☐ Physician Orders Attached ☐ Other _____

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