Facility Transfer Checklist for Transportation From Long-term-care/Rehab to Hospital/Doctor

KEEP WITH PATIENT

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DATE / TIME OF TRANSFER: ____________________

FACILITY INFORMATION — *Nurse to complete top section for each visit & send info as noted:*

Resident Payer Source ☐Medicaid ☐Private Insurance ☐Private Pay ☐Skilled

Transportation by ☐Facility Van ☐Private Ambulance ☐Jaunt ☐Taxi ☐EMS ☐Other____________

Resident Name (Last, First, Middle)________________________________ Birthdate__________

Transferred from: (Facility Name) ________________________________

Facility Type ☐Nursing Home ☐Assisted Living ☐Rehab ☐Other ____________

Contact Name/Phone #________________________________ Fax #__________

Being transferred to: (Name of Facility and Location) ________________________________

Medical reason for appointment/transfer ________________________________

Code Status________________ ☐Original DDNR form sent if patient DNR

Current Isolation Status or History of Isolation for ☐MRSA ☐VRE ☐CDIFF ☐Other ____________

Baseline Mental Status: ☐A&O to Person/Place/Time ☐Fluctuating ☐Confused/Dependent

☐Facility Facesheet (Demographics) sent (include names of emergency contact and patient's doctor)

☐Medication/Allergies List sent

☐Treatment information sent (medical history related to reason for transfer)

Transport by: ☐Stretcher ☐Wheelchair ☐Wide Wheelchair ☐Ambulatory

Return transportation arrangements________________________________ Phone # __________

Time patient left facility ________________________________

☐(FOR ED VISIT) Report called to____________________ by ____________________

HOSPITAL / DOCTOR INFORMATION — *COMPLETE AND RETURN INFO TO FACILITY. CAN MAKE/KEEP COPY.*

☐Patient admitted to____________________ (Call facility above and report. Put form in chart.)

☐Full report attached or information appropriate to visit provided.

Diagnosis________________________________

☐Labs/tests done ________________________________

☐Procedures done ________________________________

☐Medications given ________________________________

☐Change in Medications ________________________________

☐Follow up arrangements made ________________________________

☐Other________________________________

☐DDNR form returned | Time patient left hospital/doctor __________

Name of Physician ____________________ | PIC ____________________

Name of Nurse/Tech____________________ | Phone ____________________

Date/Time ____________________

THIS FORM MEETS ALL FEDERAL AND STATE REQUIREMENTS FOR COMMUNICATION BETWEEN ANY FACILITY

FORM # 050107 (3/07)

GUIDELINES FOR USE OF
FACILITY TRANSFER CHECKLIST FOR TRANSPORTATION

AT FACILITY – NURSING

1. Confirm reason for patient visit to Hospital/MD.
2. Provide info below to person at facility calling to arrange transportation.
3. Complete each section of top part of form.
4. Send information as listed.
5. If sending patient to ED call report ahead.

AT HOSPITAL-DOCTOR – NURSING

1. If patient admitted, call facility to inform about location and hospital contact.
2. Complete each line or send printed report.
3. Return Durable DNR form.

CALLING TO ARRANGE TRANSPORTATION? THINGS TO CONSIDER –

What to tell the dispatcher:

- ☐ Caller's name, facility, telephone number
- ☐ Patient's Name, date of birth
- ☐ Date/time of transportation (when they need to be at the destination)
- ☐ Where patient is picked up – (street address, floor/room of building, best entrance, stairs or elevator, etc.)
- ☐ Where patient is going – (street address, floor/room of building, best entrance, stairs or elevator, etc.)
- ☐ Reason for transport ☐to Appointment ☐From Appointment ☐To ED ☐To Hospital for admit
- ☐ Type of transport ☐ambulatory ☐wheelchair ☐wide wheel chair ☐stretcher ☐BLS ☐ACLS
- ☐ Patient's weight
- ☐ Patient's equipment ☐oxygen ☐IV ☐Foley ☐Other tubing ☐Monitor/Vent ☐Walker ☐Other
- ☐ Type of Insurance