Universal Transfer Form for Nursing Home Resident

Patient's name: _____

Patient identifier number: _____ Patient's date of birth: _____

Setting discharged from: _____ Setting discharged to: _____

Patient's sex: Male _____ Female _____

Attending physician in setting discharged from: _____

Admission date: _____ Discharge date: _____

A. Admitting diagnosis: _____

B. Other diagnoses from this admission:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

C. Current diagnoses prior to admission:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

D. Surgical procedures and endoscopies during admission (include name of physician who performed the procedure)

None ____

Physician name: _____

1. _____ Date/results _____ (may attach)
2. _____ Date/results _____ (may attach)
3. _____ Date/results _____ (may attach)

E. Laboratory values (record most recent results, with date)

WBC count _____ BUN _____ Hemoglobin _____

Creatinine _____ Sodium _____ Chloride _____

Potassium _____ Bicarbonate _____ Fasting glucose _____

Other _____

F. Results and dates of pertinent studies (e.g., radiology, CT, MRI, nuclear scans; may attach)

1. _____ 3. _____
2. _____ 4. _____

Chest radiography: Date performed: _____ Results: _____ No active disease: _____

Description if abnormal: _____

G. Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Foods: _____ Reaction: _____

Other: _____ Reaction: _____

H. Admission weight: _____ Discharge weight: _____

I. Advance directives: Yes _____ No _____

CPR: _____ Artificial nutrition: _____ Further hospitalization: _____

Other: _____

(Attach copies)

J. Has patient had a recent fall? Yes _____ No _____

Did the patient wander unsafe while hospitalized? Yes _____ No _____

K. Comments on inpatient course (may attach narrative):

_____

_____

_____

L. Is the patient aware of his/her diagnoses? Yes _____ No _____

If no, why not? _____

_____

M. Patient's cognitive status for decision making:

Independent _____ Modified independence (some difficulty in new situations) _____

Moderately impaired (decisions poor) _____ Severely impaired (never/rarely makes decisions) _____

N. Is the patient a candidate for rehabilitation therapy? Yes _____ No _____

If yes, state goals for rehabilitation:

_____

_____

_____

O. Discharge medication orders:

1. _____ Rationale: _____

Dose: _____ Route: _____ Frequency: _____

2. _____ Rationale: _____

Dose: _____ Route: _____ Frequency: _____

3. _____ Rationale: _____

Dose: _____ Route: _____ Frequency: _____

P. Diet: _____

Q. Immunizations: Influenza: _____ Date: _____ Pneumococcal: _____ Date: _____ Tetanus-diphtheria: _____ Date: _____

Tests: Tuberculin skin test: _____ Results: _____ Date: _____

R. Additional orders: _____

_____

_____

S. Follow-up recommendations (e.g., consultations, tests, procedures): _____

_____

_____

T. Is patient the primary decision maker? Yes _____ No _____

If no, name of the substitute or surrogate: _____

Name of physician/designee completing form: _____

Contact phone number: _____ Extension or pager: _____

Date form completed: _____

Name of primary care physician: _____

Contact phone number: _____ Extension or pager: _____

Figure 1. Universal form to facilitate transfers to or from a nursing home. (BUN = blood urea nitrogen; CPR = cardiopulmonary resuscitation; CT = computed tomography; MRI = magnetic resonance imaging; WBC = white blood cell.)

Adapted with permission from American Medical Directors Association. Universal transfer form. http://www.amda.com/tools/universal_transfer_form.pdf. Accessed February 15, 2010.