



# Individual Transfer Form (ITF) Education for Hospital/Clinic Staff

Emergency Department/Clinic and Residential Facility  
Partnership to Improve Care Transitions for  
La Crosse Area Facility Residents

La Crosse County Transitions in Care Committee  
Fall, 2017

Last updated 11-13-17



# Transitions in Care (TIC) Steering Committee - Organizations

- Current Steering Committee membership includes:
  - La Crosse Medical Health Science Consortium (organizer)
  - Mayo Clinic Health System - Franciscan Healthcare (co-chair)
  - Gundersen Health System (co-chair)
  - Inclusa, Inc.
  - Care Wisconsin
  - La Crosse County
  - Lakeview Healthcare Center



# Purpose of TIC Subgroup

- Steering Committee identified needs for more effective communication and collaboration with assisted living facilities (ALF) and skilled nursing facilities (SNF) when residents:
  - Come in for clinic appointments
  - Come into the Emergency Room (ER) for emergent care needs
- Individual Transfer Form created to meet need



# Form – When and How to Use

- Form is initiated by facility sending patient in from:
  - Nursing Home (SNF)
  - Assisted Living Facility (ALF)
- Form will be on **Blue** paper
- Recommend one individual transfer form per provider appointment



# Form Information Impacting Patient Care

- **Purpose of Form:**
  - Promote effective two way communication of patient/resident medical information for transfers between facilities and medical providers for both Clinic appointments and Emergency Room (ER) care
  - Both Gundersen Health System and Mayo Clinic Health System – La Crosse will review blue form and return completed second page with resident

# Form Sections – Completed by Sending Facility:

## Section I – Basic Demographics

### Facility Individual Transfer Form

(Print on BLUE Paper)

<input type="checkbox"/> ER (Call for ER Transfers) <input type="checkbox"/> Clinic	MCHS <input type="checkbox"/> GHS <input type="checkbox"/> Other _____	Today's Provider:
Patient Name (First, Middle, Last):		DOB:
Preferred to be called:		
Purpose of Visit:		
Residential Facility Name:	Phone:	Ext:
Residential Fax #:	Staff Contact:	
Preferred Pharmacy:	<input type="checkbox"/> Resident manages own medications	
Send Orders To: <input type="checkbox"/> Pharmacy	<input type="checkbox"/> Residential Placement	<input type="checkbox"/> Pharmacy and Residential Placement

- Communicates:
  - Who the patient is
  - Reason why patient is entering your system
  - Which provider they are seeing (clinic appointments)
  - Where the patient is coming from with best contact information, including fax information
  - Pharmacy information and where to send orders
  - How the patient manages medications
- Gives sending facility staff a reminder to call ER staff with all ER transfers

# Form Sections – Completed by Sending Facility:

## Section II – Legal Decision Maker Information

Legal Decision Maker		
<input type="checkbox"/> Own Decision Maker: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Emergency Contact Person Name & #: _____		<b>Notified:</b> Y or N
<input type="checkbox"/> POA Name & #: _____	<b>Activated:</b> Y or N	<b>Notified:</b> Y or N
<input type="checkbox"/> Guardian Name & #: _____		<b>Notified:</b> Y or N

- Communicates:
  - How medical decisions are made for the patient – self or others
  - Who makes medical decisions for the patient and if this person has been notified of transfer/appointment
  - Details about legal documents including activation status of POA-HC

# Form Sections – Completed by Sending Facility:

## Section III – Precautions/Allergies, Isolation, & Baseline

<b>Precautions/Allergies</b>
<input type="checkbox"/> Fall <input type="checkbox"/> Chemo <input type="checkbox"/> Suicide <input type="checkbox"/> Seizure <input type="checkbox"/> Limb Alert: _____ <input type="checkbox"/> Other: See Comments <input type="checkbox"/> Swallowing/Dysphasia <input type="checkbox"/> Diabetic <input type="checkbox"/> Allergies: _____
<b>Isolation</b>
<input type="checkbox"/> Contact <input type="checkbox"/> Airborne <input type="checkbox"/> Droplet <input type="checkbox"/> Neutropenic <input type="checkbox"/> MRSA Positive <input type="checkbox"/> N/A <input type="checkbox"/> Other: See Comments
<b>Baseline Mental Status</b>
<input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Disoriented, can follow directions <input type="checkbox"/> Disoriented, cannot follow directions <input type="checkbox"/> I CAN be left alone
<b>Baseline Behavior</b>
<input type="checkbox"/> Cooperative <input type="checkbox"/> Disruptive <input type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn <input type="checkbox"/> Agitated <input type="checkbox"/> Dementia <input type="checkbox"/> Other: See Comments <input type="checkbox"/> Things that upset me: _____ <input type="checkbox"/> I express distress by: _____ <input type="checkbox"/> What calms me: _____
<b>Baseline Transfer</b>
<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assistance with 1 <input type="checkbox"/> Needs Assistance with 2 <input type="checkbox"/> Unable <input type="checkbox"/> Transfers with (equipment name): _____
<b>Sensory Needs</b>
<input type="checkbox"/> None <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Adaptive Needs: _____
<b>Elimination</b>
<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent: <input type="checkbox"/> Bowel <input type="checkbox"/> Bladder <input type="checkbox"/> Catheter

- Communicates:
  - Information regarding patient's usual status and current care needs to safely meet patient needs
  - Check box "I CAN be left alone" only if patient is able to meet all physical care needs independently and has the cognitive abilities to be safely left alone.
  - Please member that an attendant must accompany resident if he/she cannot be left alone



# Form Sections – Completed by Sending Facility:

## Section IV – Comments Section, Transportation, and Additional Information

Comments (dietary needs, equipment, skin integrity, weight, etc.)
<hr/> <hr/> <hr/>
Send: <input type="checkbox"/> Face Sheet <input type="checkbox"/> Legal Documents <input type="checkbox"/> MAR <input type="checkbox"/> POST (yellow copy)
Usual Method of Transport(i.e. taxi, bus, family) & #: _____

- Communicates:
  - Additional information about the resident to safely meet his or her needs
  - What the sending facility should send with the resident to ensure clinic/ER is able to appropriately care for and treat the resident
  - Who generally provides transportation services for the resident with contact information

# Form Sections – Completed by Clinic or ER Medical Staff:

## Section V – Page 2

Provider Individual Transfer Form

<PLACE PATIENT LABEL HERE>

Patient Name (First, Middle, Last):		DOB:
Purpose of visit:		
<b>*ER always CALL report to Facility – Facility may not be able to readmit patient:</b> <small>(Note: A patient may be unable to return to original residence if changes with Oxygen, Nebulizer, or Insulin orders, Pain Status, Cognitive Changes, Increased Supervision Needs, Mobility/Transfer, Infection/Isolation Status, Swallowing Status, Therapy/Frame Health Orders)</small>		
Current Findings/Changes:		
<b>*Provider Orders: Completed by ER/Clinic Nurse with the final signature required by the Provider</b>		
<input type="checkbox"/> No changes to treatment • Sign below • Place in transfer envelope		<input type="checkbox"/> Changes to treatment • Complete applicable areas below • Sign below • Place sheet back in transfer envelope
Treatment(s):		
New Medication(s):	Indication for each new medication (add ICD 10 code(s)):	
Discontinued Medication(s):		
Next Appointment:		
Has the pharmacy been notified of medication change? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Facility: Please fax the following to appropriate number below: <input type="checkbox"/> Guardian Paperwork <input type="checkbox"/> POA Paperwork <input type="checkbox"/> POST <input type="checkbox"/> N/A Gundersen HIMIS Fax Number: (608)775-4706      Mayo HIMIS Fax Number: (608)392-9799		
Provider Name Printed: _____		
*Provider Signature: _____ Date: _____ Time: _____		

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- Facility will use page 2 as signed provider orders
- Accepting facility **must** have signed orders for new or changed treatments and medications. This is a regulatory requirement for facilities
- May be helpful for ER/Clinic nursing staff to complete form and have licensed provider sign completed form

# Form Sections – Completed by Clinic or ER Medical Staff: Section V – Page 2 (continued)

Patient Name (First, Middle, Last):	DOB:
Purpose of Visit:	
<b>*ER always CALL report to Facility – Facility may not be able to readmit patient:</b> <i>(Note: A patient may be unable to return to original residence if changes with Oxygen, Nebulizer, or Insulin orders, Pain Status, Cognitive Changes, Increased Supervision Needs, Mobility/Transfer, Infection/Isolation Status, Swallowing Status, Therapy/Home Health Orders)</i>	
Current Findings/Changes:	

- Orders/results of visit are not immediately available to accepting facility in EPIC and not all provider types have access to EPIC. May be a delay of 2-3 days
- Often creates call backs to clinic/ER for direction and signed orders. Often delays appropriate treatment
- **Important:** Areas with **in bold** are important to discuss verbally with facility staff. Not an all inclusive checklist – included to highlight areas that may affect facility's ability to re-admit/admit the patient



# Form Sections – Completed by Clinic or ER Medical Staff:

## Section VI – Legal Decision Maker Document Needs

**Facility:** Please fax the following to appropriate number below:  Guardian Paperwork  POA Paperwork  POST  N/A  
Gundersen HIMS Fax Number: (608)775-4706 Mayo HIMS Fax Number: (608)392-9799

- Communicates:
  - To accepting facility that guardianship, POST, and/or POA-HC paperwork is not found on file within health system, if needed
  - Appropriate fax information to ensure facility can easily send in needed documents
  - N/A indicates that no legal decision maker paperwork is needed

# Contacts

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Questions?