Facility Individual Transfer Form

(Print on **BLUE** Paper)

☐ **ER (Call for ER Transfers)** ☐ Clinic	MCHS ☐ GHS ☐ Other _____	Today's Provider:
Patient Name (First, Middle, Last): Preferred to be called:		DOB:
Purpose of Visit:		
Residential Facility Name:		Phone: Ext:
Residential Fax #:		Staff Contact:
Preferred Pharmacy:		☐ Resident manages own medications

Legal Decision Maker

☐ Own Decision Maker: ☐ Yes ☐ No

☐ Emergency Contact Person Name & #: _____ **Notified:** Y or N

☐ POA Name & #: _____ **Activated:** Y or N **Notified:** Y or N

☐ Guardian Name & #: _____ **Notified:** Y or N

Precautions/Allergies

☐ Fall ☐ Chemo ☐ Suicide ☐ Seizure ☐ Limb Alert: _____ ☐ Other: See Comments

☐ Swallowing/Dysphasia ☐ Diabetic ☐Allergies:_____

Isolation

☐ Contact ☐ Airborne ☐ Droplet ☐ Neutropenic ☐ MRSA Positive ☐ N/A ☐ Other: See Comments

Baseline Mental Status

☐ Alert/Oriented ☐ Disoriented, can follow directions ☐ Disoriented, cannot follow directions

☐ I CAN be left alone

Baseline Behavior

☐ Cooperative ☐ Disruptive ☐ Wanders ☐ Withdrawn ☐ Agitated ☐ Dementia ☐ Other: See Comments

☐ Things that upset me:

☐ I express distress by:

☐ What calms me:

Baseline Transfer

☐ Independent ☐ Needs Assistance with 1 ☐ Needs Assistance with 2 ☐ Unable

☐ Transfers with (equipment name):

Sensory Needs

☐ None ☐ Speech ☐ Hearing ☐ Vision

☐ Adaptive Needs: _____

Elimination

☐ Continent ☐ Incontinent: ☐ Bowel ☐ Bladder ☐ Catheter

Comments (dietary needs, equipment, skin integrity, weight, etc.)

Send: ☐ Face Sheet ☐ Legal Documents ☐MAR ☐POST (yellow copy)

Usual Method of Transport(i.e. taxi, bus, family) & #:_____

Provider Individual Transfer Form

<PLACE PATIENT LABEL HERE>

Patient Name (First, Middle, Last):	DOB:
Send Orders To: ☐ Pharmacy ☐ Residential Facility ☐ Pharmacy and Residential Facility	
Purpose of Visit:	
***ER <u>always</u> CALL report to Facility – Facility <u>may not</u> be able to readmit patient:** *(**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**)*	
Current Findings/Changes:	
Provider Orders: Completed by ER/Clinic Nurse with *the final signature required by the Provider	
<u>☐ No changes to treatment</u> • Sign below • Place in transfer envelope	<u>☐ Changes to treatment</u> • 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:	
Pharmacy and/or facility been notified of medication change (see above)? ☐ Yes ☐ No ☐ N/A	
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	

Provider Name Printed: _____

*****Provider Signature: _____ Date: _____ Time: _____