|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Transferred from:** | | **Date of Transfer:** | | |
| **Contact Number:** | | |
| **Care Recipient Name:** | | **Date of Birth (dd/mm/yy):** | | |
| **Reason for Transfer**:  Comments | | | | |
| Comments | | | | |
| Comments | | | | |
| **Responsible Person Name:**  Tick all that apply:NOK  Power of Attorney  Healthcare proxy  OTHER:\_\_\_\_\_\_\_\_\_\_\_ | | | **Contact Number:**  **Notified?**  Yes  No | |
|
| **Insurance Number:** | **Provider**: HIP  FC WV GEHI  BF&M ARGUS COLONIAL  NONE  OTHER : | | | |
| **Medical Diagnosis/Health Conditions**: list primary diagnosis first/Current problems | | | | **Date of onset** |
| Comments | | | | Date. |
| Comments | | | | Date. |
| Comments | | | | Date. |
|  | | | |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Vital signs & time taken:** | BP: | Pulse: | Temp: | Resp Rate: | Wt: | Blood Sugar: | Pain rating: |

|  |  |  |
| --- | --- | --- |
| **Allergies :** | Medications: | Food: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Diet:** | | | Regular | | | Soft | | | Puree | | | Special: | | | | | | | |
| **Dental Status:** | | | Own teeth | | | | Upper dentures  (with patient-Y/N) | | | | | Lower dentures  (with patient-Y/N) | | | | | Bridge/partial | | Edentulous |
| **Skin integrity and location:** | | Intact | | Stage 1 | | | | Stage II | | | Stage III | | | | Stage IV | | **Treatment Regime:** | | |
| **Cognitive Status** | | | Oriented to time, persons and/or place? If not, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| Mini Mental Score & date: | | | | | | | | | | GCS score & date: | | | | | | |
| **Advanced Care directives:** | | No  Yes and indicate if:  Full Code  DNR  Directives attached | | | | | | | | | | | | | | | | | |
| **ADLs** | **Independent** | | | | **Supervision/ verbal prompts or cueing** | | | | | **Physical assistance** | | | | | | | | **Total dependence** | |
| I person | | | | 2 person | | Mechanical lift | |
| **Mobility** |  | | | |  | | | | |  | | | |  | |  | |  | |
| **Bathing** |  | | | |  | | | | |  | | | |  | |  | |  | |
| **Eating** |  | | | |  | | | | |  | | | |  | |  | |  | |
| **Toileting** |  | | | |  | | | | |  | | | |  | |  | |  | |
| **Assistive Devices:** | Type and use: Sent with patient? Y/N | | | | | | | | | | | | | | | | | | |
| **Specific Care preferences/ needs:** |  | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Prescription Medication-**  **(indicate if sent with patient by a Y or N)** | **Dosage** | **Route** | **Frequency** | **Purpose** | **Date & time of last dose given** |
|  |  |  |  |  |  |
|  |  |  |  | Purpose |  |
|  |  |  |  |  |  |
| Prescription |  |  |  |  |  |
| Prescription |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **NURSING SUMMARY:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

**Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**