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| **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. |
|  |  |

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

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| **Allergies :** | [ ]  Medications:  | [ ]  Food: |

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| **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:** |  |

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