# RESIDENT TRANSFER RECORD

## ADMINISTRATIVE INFORMATION

| RESIDENT | | | | | MARITAL STATUS S M W D SEP | RELIG. |
|---|---|---|---|---|---|---|
| BIRTH DATE | AGE | SEX | ADMIT DATE | DISC. DATE | TYPE OF TRANSPORTATION | |

MEDICARE NO.

MEDICAL NO.

SOC. SECURITY NO.

OTHER (IDENTIFY)

RESPONSIBLE PARTY/ADDRESS

PHONE #

( )

RELATIONSHIP

NOTIFIED OF TRANSFER

☐ YES ☐ NO REASON: _____

PHYSICIAN IN CHARGE AT THE TIME OF TRANSFER OR DISCHARGE — PHONE

WILL THIS PHYSICIAN CONTINUE TO CARE FOR RESIDENT? ☐ YES ☐ NO

IF NO, PHYSICIAN FOR CONTINUE CARE — CITY — PHONE # ( )

REHAB POTENTIAL

RESIDENT INFORMED OF MEDICAL CONDITION ☐ YES ☐ NO REASON _____

ALLERGIES

DIAGNOSIS

REASON FOR TRANSFER

VITAL SIGNS: T _____ PR_____ RR_____ BP_____

PAIN RATING_____

IMMUNIZATIONS:

☐ PNEUMOCOCCAL ☐ YES, DATE:_____ ☐ NO / UNKNOWN
☐ OFFERED ☐ DECLINED

☐ INFLUENZA ☐ YES, DATE:_____ ☐ NOT IN FACILITY DURING FLU SEASON
☐ OFFERED ☐ DECLINED

☐ PPD/TB SCREENING ☐ YES, DATE:_____ RESULTS:_____

OTHER PERTINENT INFORMATION (THERAPISTS, DIETITIAN, SOCIAL SERVICE, ETC.)

TRANSFERRED TO — ADDRESS — PHONE

TRANSFERRED FROM — ADDRESS — PHONE

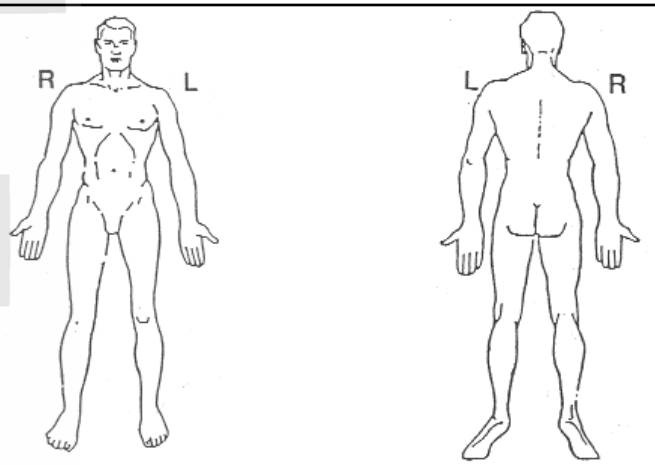
## NURSING INFORMATION

| | INDEP | ASSIST | UNABLE | | USUALLY | OCC | RARELY |
|---|---|---|---|---|---|---|---|
| BATHE | | | | ABLE TO COMMUNICATE | | | |
| DRESS | | | | MOTIVATED TO SELF CARE | | | |
| EATING | | | | FOLLOWS DIRECTIONS | | | |
| PERSONAL HYGIENE | | | | BOWEL CONTROL (DATE LAST BM ) | | | |
| TRANSFERS | | | | BLADDER CONTROL (DATE CAT INSERTED ) | | | |
| AMBULATE | | | | POSTURAL SUPPORTS | | | |

☐ AMB CANE ☐ CRUTCH ☐ WALKER ☐ ALERT ☐ CONFUSED ☐ FORGETFUL ☐ NOISY ☐ WANDERS

PSYCHOSOCIAL:

### SKIN & BODY ASSESSMENT




COMMENTS_____

RESIDENT POSSESSIONS TRANSFERRED

☐ DENTURES
☐ HEARING AID
☐ GLASSES
☐ PROSTHESIS:_____
☐ JEWELRY:_____
☐ OTHER:_____

DIET

TIME OF PREVIOUS MEAL

CURRENT MEDICATIONS INCLUDE DATE AND TIME LAST DOSE

LANGUAGES SPOKEN AND UNDERSTOOD

COPIES OF RECORDS SENT WITH PATIENT:

☐ PHYSICIANS ORDERS ☐ X-RAYS ☐ OTHERS_____
☐ HISTORY AND PHYSICAL ☐ LAB ☐ MDS
☐ MEDICATION SHEET ☐ FACE SHEET ☐ PREFERRED INTENSITY-SELF DETERMINATION

_____ DATE

_____ SIGNATURE