Nursing Home to Hospital Transfer Form

INTERACT®
Version 3.0 Tool

Resident Name *(last, first, middle initial)* _____
Language: ☐ English ☐ Other _____ Resident is: ☐ SNF/rehab ☐ Long-term
Date Admitted *(most recent)* _____/_____/_____ DOB _____/_____/_____
Primary diagnosis(es) for admission _____

Sent To *(name of hospital)* _____
Date of transfer _____/_____/_____
Sent From *(name of nursing home)* _____ Unit _____

Contact Person _____
Relationship *(check all that apply)*
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (_____) _____
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

Who to Call at the Nursing Home to Get Questions Answered
Name / Title _____
Tel (_____) _____

Primary Care Clinician in Nursing Home ☐ MD ☐ NP ☐ PA
Name _____
Tel (_____) _____

Code Status ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain

Key Clinical Information
Reason(s) for transfer _____
Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____
Relevant diagnoses ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ Ca *(active treatment)* ☐ Dementia ☐ Other _____
Vital Signs BP _____ HR _____ RR _____ Temp _____ O2 Sat _____ Time taken *(am/pm)* _____
Most recent pain level _____ (☐ N/A) Pain location: _____
Most recent pain med _____ Date given _____/_____/_____ Time *(am/pm)* _____

Usual Mental Status:
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert

Usual Functional Status:
☐ Ambulates independently
☐ Ambulates with assistive device
☐ Ambulates only with human assistance
☐ Not ambulatory

Additional Clinical Information:
☐ SBAR Acute Change in Condition Note included
☐ Other clinical notes included
For residents with lacerations or wounds:
Date of last tetanus vaccination *(if known)* _____/_____/_____

Devices and Treatments
☐ O2 at _____ L/min by ☐ Nasal canula ☐ Mask (☐ Chronic ☐ New)
☐ Nebulizer therapy; (☐ Chronic ☐ New)
☐ CPAP ☐ BiPAP ☐ Pacemaker ☐ IV ☐ PICC line
☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator
☐ Enteral Feeding ☐ TPN ☐ Other _____

Isolation Precautions
☐ MRSA ☐ VRE
Site _____
☐ C. difficile ☐ Norovirus
☐ Respiratory virus or flu
☐ Other _____

Allergies
_____
_____
_____
_____
_____

Risk Alerts
☐ Anticoagulation ☐ Falls ☐ Pressure ulcer(s) ☐ Aspiration ☐ Seizures
☐ Harm to self or others ☐ Restraints ☐ Limited/non-weight bearing: (☐ Left ☐ Right)
☐ May attempt to exit ☐ Swallowing precautions ☐ Needs meds crushed
☐ Other _____

Personal Belongings Sent with Resident
☐ Eyeglasses ☐ Hearing Aid
☐ Dental Appliance ☐ Jewelry
☐ Other _____
_____

Nursing Home Would be able to Accept Resident Back Under the Following Conditions
☐ ER determines diagnoses, and treatment can be done in NH ☐ VS stabilized and follow up plan can be done in NH
☐ Other _____

Additional Transfer Information on a Second Page:
☐ Included ☐ Will be sent later

Form Completed By *(name/title)* _____ **Signature** _____
Report Called in By *(name/title)* _____
Report Called in To *(name/title)* _____ Date _____/_____/_____ Time *(am/pm)* _____

Nursing Home to Hospital Transfer Form *(additional information)*

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Not critical for Emergency Room evaluation; may be forwarded later if unable to complete at time of transfer.

RECEIVER: PLEASE ENSURE THIS INFORMATION IS DELIVERED TO THE NURSE RESPONSIBLE FOR THIS PATIENT

Resident Name *(last, first, middle initial)* _____

DOB _____/_____/_____ Date transferred to hospital _____/_____/_____

Contact at Nursing Home for Further Information

Name / Title _____

Tel (_____) _____

Social Worker

Name _____

Tel (_____) _____

Family and Other Social Issues *(include what hospital staff needs to know about family concerns)* _____

Behavioral Issues and Interventions

Primary Goals of Care at Time of Transfer

☐ Rehabilitation and/or Medical Therapy with intent of returning home

☐ Chronic long-term care

☐ Palliative or end-of-life care

☐ Receiving hospice care ☐ Other _____

Treatments and Frequency *(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN)*

Diet

Needs assistance with feeding? ☐ No ☐ Yes

Trouble swallowing? ☐ No ☐ Yes

Special consistency *(thickened liquids, crush meds, etc…)?* ☐ No ☐ Yes

Enteral tube feeding? ☐ No ☐ Yes *(formula/rate)* _____

Skin/Wound Care

Pressure Ulcers *(stage, location, appearance, treatments)*

Immunizations

Influenza:

Date _____/_____/_____

Pneumococcal:

Date _____/_____/_____

Physical Rehabilitation Therapy

Resident is receiving therapy with goal of returning home? ☐ No ☐ Yes

Physical Therapy: ☐ No ☐ Yes

Interventions _____

Occupational Therapy: ☐ No ☐ Yes

Interventions _____

Speech Therapy: ☐ No ☐ Yes

Interventions _____

ADLs Mark I = Independent D = Dependent A = Needs Assistance

Bathing _____ Dressing _____ Transfers _____

Toileting _____ Eating _____

☐ Can ambulate independently _____

☐ Assistive device *(if applicable)* _____

☐ Needs human assistance to ambulate _____

Impairments – General

☐ Cognitive ☐ Speech ☐ Hearing

☐ Vision ☐ Sensation

☐ Other _____

Impairments – Musculoskeletal

☐ Amputation ☐ Paralysis ☐ Contractures

☐ Other _____

Continence

☐ Bowel ☐ Bladder

Date of last BM _____/_____/_____

Additional Relevant Information _____

Form Completed By *(name/title)* _____

If this page sent after initial transfer: Date sent _____/_____/_____ Time *(am/pm)* _____

Signature _____