FORM ID – GENPATITRAN

ROOKS COUNTY RCH HEALTH CENTER

1210 N. Washington | PO Box 389
Plainville, KS | (785) 434–4553
http://www.rookscountyhealthcenter.com

ACCT –

PATIENT TRANSFER FORM

PATIENT LAST NAME / FIRST NAME / MI	SEX	HEALTH INSURANCE CLAIM NUMBER
PATIENT'S ADDRESS (Street, City, State, Zip Code)	DATE OF BIRTH	RELIGION
DATE OF THIS TRANSFER	FACILITY NAME AND ADDRESS TRANSFERRING TO	PHYSICIAN IN CHARGE AT TIME OF TRANSFER Will this physician care for resident after admission to new facility? ❒ Yes ❒ No
DATES OF STAY AT FACILITY TRANSFERRING FROM	PAYMENT SOURCE FOR CHARGES TO RESIDENT ❒ SELF OR FAMILY ❒ BLUE CROSS/BLUE SHIELD ❒ PUBLIC AGENCY (give name) ❒ PRIVATE INSURANCE ❒ EMPLOYER OR UNION ❒ OTHER (Explain)	
NAME AND ADDRESS OF FACILITY TRANSFERRING FROM	NAME AND ADDRESSES OF ALL HOSPITALS AND EXTENDED CARE FACILITIES FROM WHICH RESIDENT WAS DISCHARGED IN PAST 60 DAYS	
CLINIC APPOINTMENT DATE TIME ATTACH CLINIC APPOINTMENT CARD	DATE OF LAST PHYSICAL EXAMINATION	
RELATIVE OR GUARDIAN Name	Address	Phone Number

DIAGNOSES AT TIME OF TRANSFER — EMPLOYMENT RELATED: ❒ YES ❒ NO

(a) Primary

(b) Secondary

VITALS AT TIME OF TRANSFER

T________ P________ R________ B/P________

(Check if present)

Disabilities
- ❒ Amputation
- ❒ Paralysis
- ❒ Contracture
- ❒ Decub. ulcer

Incontinence
- ❒ Bowel
- ❒ Bladder
- ❒ Saliva

Impairments
- ❒ Mental
- ❒ Speech
- ❒ Hearing
- ❒ Vision
- ❒ Sensation

Activity Tolerance Limitations
❒ None ❒ Moderate ❒ Severe

Resident knows of diagnosis?
❒ Yes ❒ No

Potential for Rehabilitation
❒ Good ❒ Fair ❒ Poor

IMPORTANT MEDICAL INFORMATION
(State allergies, if any)

ADVANCE DIRECTIVES
❒ Yes ❒ No ❒ Copy attached

CODE STATUS

DIET, DRUGS, AND OTHER THERAPY

Diet Order: at Time of Discharge

❒ May use generic substitutes

(Physician, please sign below)

Last B.M.	Date_____/_____/_____	
TB Test	Date_____/_____/_____	Type__________ Result______________________
Chest X–Ray	Date_____/_____/_____	Result______________________________________
CBC	Date_____/_____/_____	Result______________________________________
Serology	Date_____/_____/_____	Result______________________________________
Urinalysis	Date_____/_____/_____	Result______________________________________

SUGGESTIONS FOR ACTIVE CARE

BED
Position in good body alignment and change position ever ______ hrs.
Avoid ________________ position.
Prone position ___________ time/day as tolerated.

SIT IN CHAIR
__________ hrs. _________ times/day

WEIGHT BEARING
Full __________ Partial __________ None

LOCOMOTION
Walk _______________ times/day.

EXERCISES
Range of motion _____________ times/day
to _________________________________.

by resident ___________________ nurse family
Other as outlined below___________________
Stand___________ Min.__________ times/day.

SOCIAL ACTIVITIES
Encourage group________ individual__________
within_________ outside________ home.

Transport Ambulance_______ Car________
Car for handicapped _______ Bus________

Physician/Nurse Signature

Date/Time Signed

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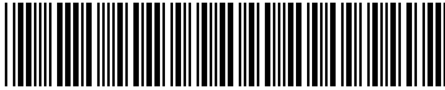

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PATIENT TRANSFER FORM – page 2 – PATIENT INFORMATION

SELF CARE STATUS
(Check level of ability. Write S in space if needs supervision only. Draw line across if inapplicable.)

	Independent	Needs Assistance	Unable To Do	
Bed Activity				Turns
				Sits
Personal Hygiene				Face, Hair, Arms
				Trunk & Perineum
				Lower Extremities
				Bladder Program
				Bowel Program
Dressing				Upper Extremities
				Trunk
				Lower Extremities
				Appliance, Splint
Feeding				
Transfer				Sitting
				Standing
				Tub
				Toilet
Loco–motion				Wheelchair
				Walking
				Stairs

BED Low_____ Mattress: Firm_____ Reg._____
Other ___________________________________
Side Rails: ❐ Yes ❐ No

BEHAVIOR
Cooperative__________ Oriented X __________
Disruptive_____ Belligerent_____ Combative_____
Senile_____ Suspicious_____ Withdrawn_____
Wanders_____

MENTAL STATUS
Alert_____ Forgetful_____ Confused_____

COMMUNICATION ABILITY	Yes	No
Able to make needs known	_____	_____
Can speak	_____	_____
Can hear	_____	_____
Can write	_____	_____
Understands speaking	_____	_____
Understands writing	_____	_____
Understands gestures	_____	_____
Understands English	_____	_____

If no, state language spoken: ___________________

ADDITIONAL PERTINENT INFORMATION
(Explain necessary details of care, diagnosis, medications, treatments, prognosis, teaching habits, preferences, etc. Therapists and social workers add signature and title to notes.)

DIET
Regular____ Low Salt____ Diabetic____
Bland_____________ Low Residue____________
Other_____________________________________
Feeds self__________ Needs help_________
Part_______________ All______________

RESIDENT USES
Appliance _________________________________
Catheter (date of last change) ________________
Colostomy______ Cane______ Crutches______
Prosthesis______ Walker______ Chair______

OTHER EQUIPMENT

SOCIAL INFORMATION
(Adjustment to disability, emotional support from family, motivation for self care, socializing ability, financial plan, family health problem, etc.)

Physician/Nurse Signature

Date/Time Signed