COUNTY HOSPITAL
LONG TERM CARE TRANSFER FORM

Patient Name: _______________________________ Date Admitted: _____________________

Discharged To: ___________________________ Date Discharged: ______________________

Admit to: ( ) Skilled Care; ( ) Intermediate Care; ( ) Personal Care

Most recent Chest X-Ray Date: _______________ DNR: ( ) Yes; ( ) No

Allergies: __________________________________ Advanced Directive: ( ) Yes; ( ) No


Items with * require explanation in "notes" section of this document.

Activities
( ) Assist with positioning  ( ) Clear
( ) Sits & positions self  ( ) Slurred
( ) Special positioning required*  ( ) Unable to understand
( ) Bedrest  ( ) Does not speak

Activities of Daily Living
( ) Requires help dressing  ( ) Communicates via method
( ) Requires help eating  other than speaking*
   Appetite: ( ) Good; ( ) Fair; ( ) Poor
( ) Requires help bathing  ( ) Foreign Language*
( ) Requires help transferring  ( ) Dentures
( ) Independent in all areas  ( ) Upper

Ambulation
( ) Able to walk  ( ) Lower
( ) Requires 1 or 2 assistants  ( ) Partial
( ) Uses wheelchair only  ( ) With patient
( ) Uses walker
( ) Uses cane or crutches
( ) Independent in all areas

Bowel/Bladder
( ) Incontinent of urine  ( ) Good
( ) Incontinent of stool  ( ) Fair
( ) Foley
    Date inserted/last changed: _______________
    Last BM: __________________
    Color/Character: _______________________

Speech
( ) Indicates hearing aid

Hearing
( ) Good  ( ) (L) ear
( ) Fair  ( ) (R) ear
( ) Poor  ( ) Hearing Aids with patient
( ) Hearing Aids

Vision
( ) Good
( ) Fair
( ) Poor
( ) Eye glasses
( ) Contacts
( ) With patient

Other prosthetics
__________________________________________
Does patient have skin integrity problems at time of discharge? ( ) Yes   ( ) No
*If yes, ( ) Redness only
( ) Open Area
Length_________ Width_________ Location_____________________________
Drainage? ( ) **Yes ( ) No
**Amount:________________________________________
**Color:________________________________________
**Odor:________________________________________
( ) Tissue Necrosis
( ) Tissue Granulation

Description of area to include color of surrounding tissue:
________________________________________________________________________
________________________________________________________________________

Decubitus Care/Date/Time:______________________________________

Notes/Activity Precautions/Additional Information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Nursing Report Called To:__________________________________________

________________________________________
Transferring Nurse’s Signature  Date/Time

The following information from the patient’s hospital medical record should be copied and sent with the patient:

Face Sheet
History and Physical
Discharge Summary
Medication Administration Record
IV Administration Record

Lab Reports
Chest X-ray Reports
Last 72 hours of Nursing Notes
Copies of DNR Order and/or Advanced Directives

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