## Patient Transfer Form

**Hospital**

**Patient Transfer Form**

1. **Patient's Last Name**: [Blank]
2. **First Name**: [Blank]
3. **MI**: [Blank]
4. **Sex**: M, F
5. **Health Insurance Claim Number**: [Blank]
6. **Address (Street Number, City, State, Zip Code)**: [Blank]
7. **Date of Birth**: [Blank]
8. **Religion**: [Blank]

### 7. Date of this transfer

<table>
<thead>
<tr>
<th>Admission</th>
<th>Discharge</th>
</tr>
</thead>
</table>

### 8. Facility Name and Address Transferring To

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
</tr>
</thead>
</table>

### 10. Physician in Charge at Time of Transfer

Will this physician care for patient after admission to new facility? Y, N

### 11. Dates of Stay at Facility Transferring From

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
</table>

### 12. Name and Address of Facility Transferring From

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
</table>

### 13. Name and Address of All Hospitals and Extended Care Facilities from Which Patient Was Discharged in Past 60 Days

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
</table>

### 14. Payment Source for Charges to Patient

<table>
<thead>
<tr>
<th>Source</th>
<th>(Give name)</th>
</tr>
</thead>
</table>

### 15. Clinic Appointment

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Card</th>
<th>Appointment Card</th>
<th>Date of Last Physical Examination</th>
</tr>
</thead>
</table>

### 16. Diagnoses at Time of Transfer

1. **Primary**
2. **Secondary**

### 17. Employment Related

A, B, C, D, E

### Diet, Drugs, and Other Therapy

**At Time of Discharge**

<table>
<thead>
<tr>
<th>Diet or Drug</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

**Important Medical Information**

<table>
<thead>
<tr>
<th>State Allergies If Any</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

### Suggestions for Active Care

- **Bed**
  - Position in good body alignment and change position every _____ hours.

- **Locomotion**
  - Walk: _____ times/day.

- **Sit in Chair**
  - _____ hrs. _____ times/day.

- **Exercises**
  - Range of motion _____ times/day.

**Weight Bearing**

- Full: _____ Partial: _____ None: _____

- on _____ leg

**Social Activities**

- Encourage group: _____ individual: _____

- within _____ outside _____ home

**Transport**

- Ambulance: _____ Car: _____

- Car for handicapped: _____ Bus: _____

**Signature of Physician or Nurse**: [Blank]

**Date**: [Blank]