SNF/NF to Hospital Transfer Form

INTERACT
Version 4.0 Tool

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

Key Clinical Information

Reason(s) for transfer _____

Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: _____
Relevant diagnosis
☐ Heart Failure Ejection Fraction if known _____% Most recent Echo (date) ____/____/____
☐ COPD ☐ CKD ☐ DM Most recent Glucose (date/time) _____ On scheduled insulin ☐ Yes ☐ No
☐ Cancer (active treatment) ☐ Dementia ☐ Other(s) _____
Vital signs BP _____ HR _____ RR _____ Temp _____ O2 Sat _____ Date/time taken (am/pm) _____
Most recent pain level _____ (☐ N/A) Pain location _____
Most recent pain med _____ Date given ____/____/____ Time (am/pm) _____

Code Status: Other (describe) ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort care only ☐ Uncertain
Resident/Patient Decision Making Capacity ☐ Capable ☐ Requires proxy

Allergies

_____
_____

Usual Functional Status before the Acute Change in Condition

Mobility
☐ Ambulates independently ☐ Ambulates with assistive device
☐ Ambulates only with human assistance ☐ Not ambulatory

ADLs *(check all that apply)*
I = Independent
A = Needs Assistance
D = Totally Dependent

Bathing	☐ **I**	☐ **A**	☐ **D**
Dressing	☐ **I**	☐ **A**	☐ **D**
Toileting	☐ **I**	☐ **A**	☐ **D**
Transfers	☐ **I**	☐ **A**	☐ **D**
Eating	☐ **I**	☐ **A**	☐ **D**

Sensory Impairment ☐ Vision ☐ Hearing
Bladder Function ☐ Continent ☐ Incontinent
☐ Urinary catheter in place (Date inserted ___/___/___)
Reason for catheter ☐ Retention ☐ Skin Protection ☐ Monitor output
☐ Other (describe)
Bowel Function ☐ Continent ☐ Incontinent ☐ Ostomy
Date of last bowel movement (if known) ____/____/____

Usual Mental Status/Cognitive Function before the Acute Change in Condition

☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert

Personal Belongings Sent with Resident/Patient

☐ Eyeglasses ☐ Hearing aid ☐ Dental appliance
☐ Jewelry ☐ Other _____
_____

Sent To *(name of hospital)* _____
Date of Transfer ____/____/____
Sent From *(name of SNF/NF)* _____ Unit _____

Resident Representative

_____
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 SNF/NF to Get Questions Answered

Name / Title _____
Tel (____) _____

Primary Care Clinician in SNF/NF

☐ MD ☐ NP ☐ PA
Name _____
Tel (____) _____

SNF/NF to Hospital Transfer Form *(second page)*

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Resident /Patient Name *(last, first, middle initial)* _____ DOB ____/____/____
Date Transferred to hospital ____/____/____

Treatments

Respiratory

- ☐ O2 at ____ L/min by ☐ Nasal cannula ☐ Mask ☐ Chronic ☐ New
- ☐ Nebulizer therapy ☐ Chronic ☐ New
- ☐ CPAP ☐ BiPAP

Diet

- ☐ Enteral feeding; Formula _____ Rate _____
  Free water bolus: cc _____ hrs _____
- ☐ TPN
- ☐ Special consistency (thickened liquids, crush meds, etc.) describe
  _____

Medications

- ☐ On antibiotics: Name _____
  Indication _____ Treatment duration
  Date started ____/____/____ Reason _____
- ☐ On Proton pump inhibitors Reason _____
- ☐ Other treatments and frequency *(include dialysis, chemotherapy, transfusions, ostomy, radiation)* _____
  _____
  _____

Devices

- ☐ Pacemaker
- ☐ Internal defibrillator
- ☐ Parenteral lines (describe) _____
  _____
- ☐ Ports (describe) _____
  _____
- ☐ AV shunt (describe) _____
  _____
- ☐ Pain pump (describe) _____
  _____
- ☐ Bladder (Foley) catheter ☐ Chronic ☐ New

Isolation Precautions

Currently on isolation precautions ☐ Yes ☐ No

Multiple Drug Resistant Organism (MDRO) ☐ Yes ☐ No
If yes, specify: Organism _____ Site of infection _____
Active infection ☐ Yes ☐ No

Significant communicable disease

- ☐ C. diff
- ☐ Other (lice, scabies, disseminated shingles, norovirus, flu, TB, etc.)
  _____

Risk Alerts

- ☐ Agitation with risk to harm self or others
- ☐ Anticoagulation
  Medication _____
  _____
  Reason _____
- ☐ Aspiration
- ☐ High fall risk
- ☐ Limited/non-weight bearing ☐ Left ☐ Right
- ☐ May attempt to exit
- ☐ Needs meds crushed
- ☐ Pressure ulcers/injuries
- ☐ Restraints
- ☐ Seizures
- ☐ Swallowing precautions
- ☐ Other _____

Skin/Wound Care

- ☐ Pressure ulcers/injuries *(stage, location)* _____
- ☐ Other wounds or bruises present ☐ Yes ☐ No *(describe type, location)* _____

Immunizations

- ☐ Influenza *(date* ____/____/____
- ☐ Pneumococcal *(date)* ____/____/____
- ☐ Tetanus *(date)* ____/____/____
- ☐ Shingles *(date)* ____/____/____

PPD status *(if known)* ☐ Negative ☐ Positive ☐ Unknown

Behavioral Issues and Interventions

_____
_____
_____
_____

Contact SNF/NF for Further Information

Name / Title _____
Tel (____) _____

Rehabilitation Therapy

Is the Resident/Patient currently receiving Rehabilitation Therapy?
☐ Yes ☐ No

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