# SNF/NF to Hospital Transfer Form

## 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

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<thead>
<tr>
<th>Activity</th>
<th>☐ I</th>
<th>☐ A</th>
<th>☐ D</th>
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<tbody>
<tr>
<td>Bathing</td>
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<td>Dressing</td>
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<td>Transfers</td>
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<tr>
<td>Eating</td>
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### 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 (describe) __________________________

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 (____) __________________________

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

**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 ___________________________ Treatment duration ___________________________
- Indication ___________________________ Date started __________ / ______ / ______ Reason ___________________________
- On Proton pump inhibitors □ Reason ___________________________
- Other treatments and frequency (include dialysis, chemotherapy, transfusions, ostomy, radiation) ___________________________

### 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.) describe ______

### 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) ___________________________
Report Called in By (name/title) ___________________________
Report Called in To (name/title) ___________________________
Date __________ / ______ / ______ Time (am/pm) ______

**Signature** ___________________________

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**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 ___________________________

**Devices**
- □ Pacemaker
- □ Internal defibrillator
- □ Parenteral lines (describe) ___________________________
- □ Ports (describe) ___________________________
- □ AV shunt (describe) ___________________________
- □ Pain pump (describe) ___________________________
- □ Bladder (Foley) catheter □ Chronic □ New

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