Hospital to Post-Acute Care Transfer Form

INTERACT®
Version 4.5 Tool

A. Patient Information

Name _____

DOB _____/_____/_____ Gender: ☐ M ☐ F

Language: ☐ English ☐ Other _____

Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other _____

B. Respresentative/Caregiver/ Proxy Contact

Family/Caregiver Name _____

Tel (_____) _____

Healthcare Proxy/Guardian Name *(if different)* _____

Tel (_____) _____

C. Advance Directives/Goals of Care

☐ Full Code ☐ DNR ☐ DNI (Do Not Intubate)

☐ DNH (Do Not Hospitalize) ☐ No Artificial Feeding ☐ Comfort Care

☐ Hospice Care

☐ Other *(specify)* _____

Were goals of care discussed during this hospitalization? ☐ No ☐ Yes *(specify)*

_____

Patient decision making capacity? ☐ Capable of making decisions

☐ Requires proxy

D. Transferring Hospital Information

Hospital _____

Unit _____

Discharging RN _____

Tel (_____) _____

Discharging MD _____

Tel/Page (_____) _____

Date of Admission to Hospital _____/_____/_____

E. Post-Acute Care Information

Transfered to _____ Tel (_____) _____

Nurse to Nurse verbal report? ☐ No ☐ Yes *(specify to whom)* _____

F. Hospital Physician Care Team Information

Primary Care Physician *(or Hospitalist)* _____ Tel (_____) _____

Specialist _____ Specialty _____ Tel (_____) _____

Specialist _____ Specialty _____ Tel (_____) _____

G. Key Clinical Information

Vital Signs Time Taken _____ Pain Rating _____ ☐ N/A Pain Site _____

Temp _____ BP _____ HR _____ RR _____ O2 Sat _____ Weight _____

Mental Status ☐ Alert ☐ Disoriented, follows commands ☐ Disoriented, cannot follow commands ☐ Not Alert

Diagnoses Primary Discharge Diagnosis _____

Other Medical Diagnoses _____

Mental Health Diagnoses _____

H. High Risk Conditions/Treatment Information *(check all that apply)*

☐ Fall Risk Precautions: _____

☐ Heart Failure: ☐ New diagnosis? ☐ Exacerbation this admission? Date of last echo _____/_____/_____ ☐ EF_____% Dry Weight *(if known)* _____

☐ Anticoagulated: Reason: ☐ Afib ☐ DVT/PE ☐ Mech. Valve ☐ Post-OP ☐ Low EF ☐ Other _____

Duration _____ Goal INR: ☐ 1.5 - 2.5 ☐ 2 - 3 ☐ Other _____

☐ On PPI: Indication(s): ☐ In-hospital prophylaxis and can be d/c ☐ Specific Dx: _____

☐ On Antibiotics: Indication(s): _____ Total Treatment Course _____ days Date started _____/_____/_____

☐ On Scheduled Insulin

☐ COVID

I. Procedures & Key Findings *(during this hospitalization)* ∗ Please Attach Reports ∗

List Procedures *(surgeries, imaging)* _____

_____

_____

Key findings _____

_____

_____

J. Medications and Allergies

☐ Medication List Attached

Please provide a HARD COPY PRESCRIPTION FOR CONTROLLED SUBSTANCES

Allergies: ☐ None known ☐ Yes *(specify)* _____

Pain med: ☐ No ☐ Yes *(specify)* _____

Dose _____

Last Dose (am/pm) _____

Hospital to Post-Acute Care Transfer Form *(cont'd)*

INTERACT® Version 4.5 Tool

K. Nursing Care

Physical and Sensory Function

Ambulation	☐ Independent	☐ With Assistance	☐ With Assistive Device	☐ Not Ambulatory
Weight Bearing	☐ Full	☐ Partial L / R	☐ None L / R	
Transfer	☐ Self	☐ 1-Person Assist	☐ 2-Person Assist	
Sensory Function	Sight: ☐ Normal ☐ Impaired ☐ Blind		Hearing: ☐ Normal ☐ Impaired ☐ Deaf	
Devices	☐ Wheelchair	☐ Walker	☐ Cane	☐ Crutches
	☐ Prosthesis	☐ Glasses	☐ Contacts	☐ Dentures
	☐ Hearing Aid L / R			
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) _____ /_____ /_____				

Nutrition and Hydration

Diet _____ Consistency _____ Free Water Restriction _____

Eating Instructions ☐ Self ☐ With Assistance ☐ Difficulty Swallowing (☐ *Attach speech therapy recommendations if available*)

Tube Feeding ☐ G-tube ☐ J-tube ☐ Date inserted _____ /_____ /_____ Free Water Bolus _____cc every_____h

☐ Tube feed product _____ Rate: _____cc/h Duration_____h/day

☐ TPN

Treatments and Therapeutic Devices

☐ PICC ☐ Portacath Date inserted _____ /_____ /_____ *(Please attach imaging report confirming placement)*

Cardiac ☐ Pacemaker ☐ ICD ☐ Other *(specify)* _____

Respiratory ☐ CPAP ☐ BiPAP ☐ O2 _____ L ☐ prn ☐ continuous ☐ Suction ☐ Trach size _____

☐ Tracheostomy Care ☐ Ventilator Care

Therapies *(please attach assessment/recommendations)*

☐ PT ☐ OT ☐ Speech ☐ Respiratory ☐ Dialysis

Skin Care

☐ No skin breakdown ☐ Pressure ulcer/injury: Stage _____ Location _____ ☐ 2nd Pressure ulcer/injury: Stage _____ Location_____

☐ Other wounds *(specify)* _____

Risks and Precautions *(check all that apply)*

☐ Fall ☐ Delirium ☐ Agitation ☐ Aggression ☐ Unescorted exiting ☐ Aspiration ☐ Other _____

Precautions _____

Infection Control Issues ☐ Other (specify) _____

Infection/Colonization ☐ MRSA ☐ VRE ☐ C.difficile ☐ ESBL ☐ Norovirus ☐ Flu/respiratory

☐ COVID: ☐ No ☐ Yes *(date):*____/___/_____

Isolation Precautions ☐ Yes ☐ No

Immunizations *(in hospital)* ☐ Influenza: ☐ No ☐ Yes *(date):* ____/___/_____ ☐ COVID: ☐ No ☐ Yes *(date):*____/___/_____

☐ Pneumococcal: ☐ No ☐ Yes *(date):* ____/___/_____ Type *(Specify which vaccine if known):* _____

L. Critical Transitional Care Information: Pending Tests and Follow-Up

Summarize high-priority care needs for next 24-48 hrs *(including essential medications, pain control, tests needed, follow-up):* _____

_____

_____

_____

Pending Lab and Test Results: _____

_____

Recommended Follow-Up Tests, Procedures, Appointments: _____

_____

_____

M. Attached Document and Notes *(check all that are included)*

☐ Admission H&P	☐ Specialist Consultations	☐ Medication Reconciliation	☐ Operative Reports	☐ Diagnostic Studies
☐ Labs	☐ Diabetic Glucose values	☐ PICC placement confirmation	☐ Rehab Therapy Notes	☐ Respiratory Therapy Notes
☐ Nutrition Notes	☐ Pain ratings	☐ Code Status	☐ Advance Directive	☐ Discharge Summary