

# EMERGENCY DEPARTMENT TO LONG-TERM CARE HANDOFF COMMUNICATION

To  SNF  ICF  RCF/ALF  Swing Bed  Rehab  LTCH  Group Home  Other \_\_\_\_\_

Hospital	LTC Community
Address	Address
Phone _____ Fax _____	Phone _____ Fax _____

**RECORDS SENT WITH PATIENT OR FAXED TO RECEIVING FACILITY**

- |   |   |
|---|---|
| <input type="checkbox"/> Face Sheet   | <input type="checkbox"/> Signed hard copy of controlled substance prescriptions if applicable |
| <input type="checkbox"/> Medication Reconciliation Record                   | <input type="checkbox"/> Physician and Nurses Notes   |
| <input type="checkbox"/> This Form  | <input type="checkbox"/> ED Treatment Sheet   |
| <input type="checkbox"/> Lab/Radiology/Special Studies Reports if available | <input type="checkbox"/> Other _____  |

**BELONGINGS SENT WITH PATIENT**

- |   |  |                                    |   |                               |
|---|--|------------------------------------|---|-------------------------------|
| <input type="checkbox"/> Eyeglasses/Contacts  | <input type="checkbox"/> Dentures/Partial Plates | <input type="checkbox"/> Upper     | <input type="checkbox"/> Lower          | <input type="checkbox"/> Both |
| <input type="checkbox"/> Hearing Aid(s) <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Brace                   | <input type="checkbox"/> Wound Vac | <input type="checkbox"/> None           |                               |
| <input type="checkbox"/> Cane   | <input type="checkbox"/> Walker                  | <input type="checkbox"/> Splints   | <input type="checkbox"/> Jewelry (list) | _____                         |

**PHYSICIAN ORDERS AND FOLLOW-UP APPOINTMENTS**  See Medication Reconciliation Record  See Physician Order Sheet

ED Diagnosis/Primary Findings/Treatments \_\_\_\_\_

New/Changed Medication	Dose/Frequency/Route	First Dose Given	Next Dose Due	Prescription Written
_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date ___/___/___ Time _____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date ___/___/___ Time _____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date ___/___/___ Time _____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date ___/___/___ Time _____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date ___/___/___ Time _____	<input type="checkbox"/>

Follow up labs/tests/physician appointments \_\_\_\_\_

Labs/Tests Pending  Yes  No Tests Pending \_\_\_\_\_ If yes, call \_\_\_\_\_ for report.

Diet <input type="checkbox"/> Resume Diet	Activity <input type="checkbox"/> Resume Activity
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**Additional Orders**

**DISCHARGE INFORMATION**

- Have you addressed discharge planning needs and transportation?  Yes  No
- Any change in skin condition from LTC transfer form?  Yes  No  NA If yes, describe in nurses notes.
- Have you addressed with the LTC facility, the resident's need for NEW prescriptions until LTC pharmacy services are available?  Yes  No  NA

Current Vital Signs BP \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ Pulse Ox \_\_\_\_\_ Time \_\_\_\_\_

- This patient is stable for transfer and has no emergency medical condition.  
 (The EMTALA form must also be completed if the patient is transferring to the same or a higher level of care.)

ED Discharge Date \_\_\_/\_\_\_/\_\_\_ ED Discharge Time \_\_\_\_\_ Transportation Mode \_\_\_\_\_

Verbal Report Given By (print name/title) \_\_\_\_\_

Verbal Report Received By (print name/title) \_\_\_\_\_ Time Report Called \_\_\_\_\_

Notes \_\_\_\_\_

Notes to LTC Patient Questions Call \_\_\_\_\_ Requests for Additional Medical Records Call \_\_\_\_\_

Attending Physician/PCP Called \_\_\_\_\_ / \_\_\_/\_\_\_ Time \_\_\_\_\_

Physician's Signature _____ _____/____/____ Time _____	Nurse's Signature _____ _____/____/____ Time _____
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Place hospital logo here

**PLACE PATIENT LABEL HERE OR COMPLETE**

Patient Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Medical Record or SS # \_\_\_\_\_