

# HOSPITAL TO LONG-TERM CARE HANDOFF COMMUNICATION — Page 1 of 3

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

Hospital	LTC Facility
Patient Care Unit	Accepting Physician/PCP
Unit Phone	Unit Fax
Phone Number	Fax Number

Admission Date \_\_\_/\_\_\_/\_\_\_ Reason for hospitalization \_\_\_\_\_ Discharge Date \_\_\_/\_\_\_/\_\_\_

**ALLERGIES**  No Known Allergies

<input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Guardian Name _____ Phone _____	Advance Directives Yes <input type="checkbox"/> No <input type="checkbox"/> Capable of making own decisions <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Health Care Decision Maker or Local Contact Notified of Transfer Name _____ Phone _____	Speaks English <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify _____ Religious/Literacy Concerns _____ <input type="checkbox"/> None
Admissions to Other Hospitals/Facilities in Past Month <span style="float: right;"><input type="checkbox"/> None <input type="checkbox"/> Unknown</span>	

**CHECK ALL THAT APPLY**

**Mental Status**  Alert  Oriented  Non-Verbal  Unresponsive  Confused  Uncooperative  Disruptive  Withdrawn  Depressed

<b>Impairments</b> <input type="checkbox"/> None	<input type="checkbox"/> Mental (describe) _____	<input type="checkbox"/> Speech (describe) _____	<input type="checkbox"/> Hearing (describe) _____	<input type="checkbox"/> Vision (describe) _____	<input type="checkbox"/> Sensation (describe) _____
<b>Disabilities</b> <input type="checkbox"/> None	<input type="checkbox"/> Amputation (describe) _____	<input type="checkbox"/> Prosthesis (describe) _____	<input type="checkbox"/> Contracture (describe) _____	<input type="checkbox"/> Paralysis (describe) _____	

**Fall In Hospital**  No  Yes \_\_\_/\_\_\_/\_\_\_ Injury  No  Yes (describe) \_\_\_\_\_

**Infection**  Active MRSA  Colonized MRSA Site \_\_\_\_\_  Active VRE  Colonized VRE Site \_\_\_\_\_  
 C. difficile Positive  Diarrhea Present  UTI  TB  Wound Site \_\_\_\_\_  Other \_\_\_\_\_  Not Applicable

**Bowel**  Continent  Incontinent  Ostomy Type \_\_\_\_\_ Changed \_\_\_/\_\_\_/\_\_\_ Last BM \_\_\_/\_\_\_/\_\_\_

**Bladder**  Continent  Incontinent  Catheter/Urostomy/Type \_\_\_\_\_ Inserted/Changed \_\_\_/\_\_\_/\_\_\_ DC'd \_\_\_/\_\_\_/\_\_\_

**IV**  None IV Access Type \_\_\_\_\_ Location \_\_\_\_\_ Inserted \_\_\_/\_\_\_/\_\_\_ Dsg. Changed \_\_\_/\_\_\_/\_\_\_

**Assisted Devices**  None  Cane  Walker  Wheelchair  Crutches  Other \_\_\_\_\_

**Appetite/Nutrition**  Good  Fair  Poor  Feeding Tube Type \_\_\_\_\_ Inserted/Changed \_\_\_/\_\_\_/\_\_\_

**Safety Concerns**  None  Aspiration  Skin Breakdown  Seizures  Isolation  Wander/Elope  High Risk for Falls

**Immunizations In Hospital**  None  Influenza \_\_\_/\_\_\_/\_\_\_  Pneumonia \_\_\_/\_\_\_/\_\_\_  Tetanus \_\_\_/\_\_\_/\_\_\_  TB Skin Test \_\_\_/\_\_\_/\_\_\_

<p><b>Treatment Received Within Last 14 Days *Date Last Administered*</b></p> <table style="width: 100%;"> <tr><td><input type="checkbox"/> Chemotherapy</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Radiation</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Oxygen therapy</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Suctioning</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Tracheotomy care</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Ventilator</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> IV medications</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Transfusions</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Dialysis</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Isolation for active infectious disease</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> BiPap/CPAP</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> Hospice care</td><td>___/___/___</td></tr> <tr><td><input type="checkbox"/> None of the above treatments or procedures received</td><td></td></tr> </table> <p><b>*Only complete for patients transferring to skilled nursing level of care. If dates are not recorded, the last 14 days of nurse notes and MARS must be sent to SN facility.</b></p>	<input type="checkbox"/> Chemotherapy	___/___/___	<input type="checkbox"/> Radiation	___/___/___	<input type="checkbox"/> Oxygen therapy	___/___/___	<input type="checkbox"/> Suctioning	___/___/___	<input type="checkbox"/> Tracheotomy care	___/___/___	<input type="checkbox"/> Ventilator	___/___/___	<input type="checkbox"/> IV medications	___/___/___	<input type="checkbox"/> Transfusions	___/___/___	<input type="checkbox"/> Dialysis	___/___/___	<input type="checkbox"/> Isolation for active infectious disease	___/___/___	<input type="checkbox"/> BiPap/CPAP	___/___/___	<input type="checkbox"/> Hospice care	___/___/___	<input type="checkbox"/> None of the above treatments or procedures received		<p><b>Activities of Daily Living</b></p> <table style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Independent</th> <th style="text-align: center;">Needs Help</th> <th style="text-align: center;">Unable To Do</th> </tr> </thead> <tbody> <tr><td>Walking</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Toileting</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Turning</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Bathing</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Dressing</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Feeding</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Transferring</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>		Independent	Needs Help	Unable To Do	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Place hospital logo here

**PLACE PATIENT LABEL HERE OR COMPLETE**

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

**The following items are required to be sent with ALL patients on day of discharge to any post acute care facility.**

Form	Content Needed	Date
Face Sheet	With payer sources	
Medication Administration Record	Send most current and complete MAR which includes IV IM and PO medications and flushes, blood transfusions and chemotherapy. If patient is transferring to SNF care and treatment dates not recorded on page 2, send last 14 days of MAR.	
H&P	If older than 30 days, have physician review/update/sign/date	
Physician Discharge Summary (official)	If not checked as sent, Medical Records should send a copy to the receiving facility when completed. <b>Note to receiving facility:</b> If a Physician Discharge Summary is not received within 7 days or to receive additional patient records, a request for information from the medical records department should be faxed to <b>(FAX NUMBER)</b> .	
Nursing Assessment/Nurses Notes	Send last 2 days if patient is transferring to SNF care and treatment dates not recorded on page 2, send last 14 days of nurses notes.	
Consult Reports	A copy of each consult	
Discharge Medication Reconciliation Record		
Advanced Directive/DPOA		
This Form	Fax to facility prior to discharge	

**Based on post acute care facility requirements, the following may or may not need to be sent.**

Physician Notes	The last 3 days	
PT/OT/ST/Wound Therapy	Include the evaluation and notes from the last week	
Physician Progress Notes	Last 4 days	
Pertinent Laboratory Results	Include most recent UA, C&Ss, CBC, glucose, electrolytes, and labs used in dosing meds (ie. Theophylline, Dilantin levels, INRs etc.)	
Pertinent Radiology/Special Studies Reports	Include swallowing studies, MRIs, CT Scans, ultrasounds, EKG, stress test, echo	
Operative Reports	For all major surgeries	
Preadmission Screening and Annual Resident Review (PASARR) if applicable	Complete screening for patients who are suspected of having mental illness (MI), mental retardation (MR), and/or related conditions and who are going to a Medicaid-certified LTC facilities .	

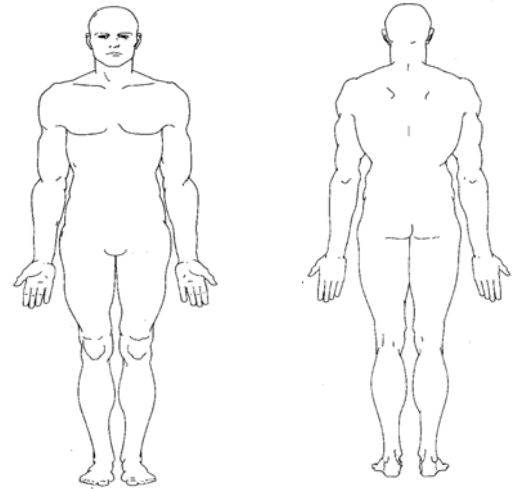
**Skin and Body Assessment**  Skin Intact  Skin Not Intact—Identify each non-intact area and drain with a number and describe site and care below.

#1 Site \_\_\_\_\_  
Care \_\_\_\_\_

#2 Site \_\_\_\_\_  
Care \_\_\_\_\_

#3 Site \_\_\_\_\_  
Care \_\_\_\_\_

#4 Site \_\_\_\_\_  
Care \_\_\_\_\_



**Pain Assessment**  None  
 Acute  Chronic  Intermittent  Sharp  Dull  Other \_\_\_\_\_  
 Location \_\_\_\_\_ Intensity (1-10) \_\_\_\_\_ Time of last pain med \_\_\_\_\_

**DISCHARGE INFORMATION**

Have you addressed discharge planning needs and transportation?  Yes  No  
 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 \_\_\_\_\_  
 Discharge Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge Time \_\_\_\_\_ Transported by  EMS  Family  LTC Facility  
 Verbal Report Given By (print name/title) \_\_\_\_\_ Given To \_\_\_\_\_ Time \_\_\_\_\_  
**Note to LTC:** Patient care questions call \_\_\_\_\_ Request for additional medical records call \_\_\_\_\_

**BELONGINGS SENT WITH PATIENT**

Eyeglasses/Contacts  Dentures/Partial Plates \_\_\_\_\_ Upper \_\_\_\_\_ Lower \_\_\_\_\_ Both  Hearing Aid(s)  Right  Left  
 Jewelry (list) \_\_\_\_\_  Cane  Walker  Splints  Brace Type \_\_\_\_\_  Wound Vac

**FORM COMPLETED BY** Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_

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**PHYSICIAN DISCHARGE ORDERS AND SUMMARY**

Primary and Secondary Diagnoses	Present on admission to hospital			Procedures/Treatments
	Yes	No	Unable to determine	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Discharge Medications	Dose/Frequency/Route (prescription must be written for Schedule II controlled substances.)	Prescription Written/Called
<input type="checkbox"/> See Medication Reconciliation Record or Discharge Medication List		
_____	Next dose due ___/___/___ Time _____	<input type="checkbox"/>
_____	Next dose due ___/___/___ Time _____	<input type="checkbox"/>
_____	Next dose due ___/___/___ Time _____	<input type="checkbox"/>
_____	Next dose due ___/___/___ Time _____	<input type="checkbox"/>
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**Labs**  INR Frequency \_\_\_\_\_  TB Test  Blood glucose test Frequency \_\_\_\_\_  Sliding Scale Insulin (see discharge meds.)

**Respiratory Care** Oxygen at \_\_\_ L/M per \_\_\_\_\_  CPAP  BiPAP  Trach  Nebulizer Treatments (see discharge meds)  
 Ventilator Type \_\_\_\_\_  T.Vol.  PEEP  PCO2  SIMV  Other \_\_\_\_\_

**Activity**  No Restrictions  Up with Assist  Bed Rest  HOB Up 30°  WB as Tolerated  Toe-Touch WB on \_\_\_\_\_ leg  Non-WB

**Durable Medical Equipment**  \_\_\_\_\_ **Code Status**  DNR  Resuscitate

**Rehab Potential**  Good  Fair  Poor **Evaluate and Treat**  PT  OT  ST

**Diet**  Regular  Cardiac  low cholesterol  low sodium  low fat  ADA \_\_\_\_\_ calories  
 Tube Feedings \_\_\_\_\_  Supplements \_\_\_\_\_  Weigh Daily

**Treatment/Dressing Changes/Other Orders**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Follow up appointments**  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient is stable for discharge and transfer to  SNF  ICF  RCF/ALF  LTCH  Other \_\_\_\_\_  
 I certify to the best of my knowledge that the narrative description of the principle and secondary diagnosis and the major procedures performed are accurate and complete.

Physician Signature \_\_\_\_\_ Print Physician Name \_\_\_\_\_ / / Time \_\_\_\_\_  
 Physician will follow?  Yes  No If no, accepting physician/PCP called \_\_\_\_\_ / / Time \_\_\_\_\_

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