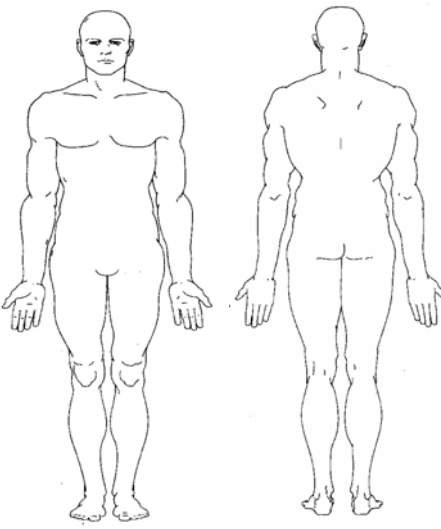


LONG-TERM CARE HANDOFF COMMUNICATION

From SNF ICF RCF/ALF Swing Bed Rehab LTCH Group Home Other _____

LTC Center		Address	
Phone		Fax	
Resident's Physician <input type="checkbox"/> Notified		Physician Phone	
Resident Name (Last, First, MI)		Date of Birth	Sex
		Social Security Number	
Reason for Transfer <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Hyper/Hypoglycemia <input type="checkbox"/> Fever <input type="checkbox"/> Chest Pain <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Other _____ <input type="checkbox"/> Injury/Fall (Describe) _____ Date/Time Onset/Injury _____			
CODE STATUS <input type="checkbox"/> See DNR Form <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/> DNR		ALLERGIES <input type="checkbox"/> No Known Allergies <input type="checkbox"/> See MAR	
<input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Guardian Name _____ Phone _____		Advance Directives <input type="checkbox"/> Yes <input type="checkbox"/> No Resident able to make 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 Hospitals/Other Facilities in Past Month		<input type="checkbox"/> None	
Chronic Conditions		<input type="checkbox"/> See Diagnosis Sheet	
Immunizations <input type="checkbox"/> None <input type="checkbox"/> Influenza ___/___/___ <input type="checkbox"/> Pneumonia ___/___/___ <input type="checkbox"/> Tetanus ___/___/___ <input type="checkbox"/> TB Skin Test ___/___/___			
CHECK ALL THAT APPLY			
Mental Status <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Unresponsive <input type="checkbox"/> Confused <input type="checkbox"/> Uncooperative <input type="checkbox"/> Disruptive <input type="checkbox"/> Withdrawn <input type="checkbox"/> Depressed			
Impairments <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) _____	
Disabilities <input type="checkbox"/> Amputation (describe) _____		<input type="checkbox"/> Prosthesis (describe) _____	
		<input type="checkbox"/> Contracture (describe) _____	
		<input type="checkbox"/> Paralysis (describe) _____	
Mobility <input type="checkbox"/> No Mobility Aids <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> W/C <input type="checkbox"/> Bed Bound <input type="checkbox"/> No Weight Bearing <input type="checkbox"/> Partial Weight Bearing _____ Leg			
Falls Last 30 Days <input type="checkbox"/> No <input type="checkbox"/> Yes ___/___/___ ___/___/___ Injury <input type="checkbox"/> No <input type="checkbox"/> Yes (describe) _____			
Infection <input type="checkbox"/> MRSA Site <input type="checkbox"/> VRE Site <input type="checkbox"/> C. difficile <input type="checkbox"/> UTI <input type="checkbox"/> Other _____			
Elimination Last BM ___/___/___ Urinary Cath. In Past Month <input type="checkbox"/> Yes <input type="checkbox"/> No Inserted/Changed ___/___/___ Discontinued ___/___/___			
Records Sent or Faxed <input type="checkbox"/> Face Sheet <input type="checkbox"/> H&P <input type="checkbox"/> Medication Administration Record (Current) <input type="checkbox"/> Physician Order Sheet (Most Recent) <input type="checkbox"/> Last Nursing Assessment <input type="checkbox"/> Current Lab & Radiology Report <input type="checkbox"/> This Form <input type="checkbox"/> Advance Directives/ DPOA <input type="checkbox"/> DNR Form <input type="checkbox"/> Diagnosis Sheet			
Belongings Sent With Resident <input type="checkbox"/> None <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"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Splint <input type="checkbox"/> Brace <input type="checkbox"/> Wound Vac <input type="checkbox"/> Jewelry (list) _____			
Skin and Body Assessment <input type="checkbox"/> Skin Intact <input type="checkbox"/> Skin Not Intact—Identify each area with a number on the diagram and describe site & care in notes below.			
		#1 Site _____ Care _____	
		#2 Site _____ Care _____	
		#3 Site _____ Care _____	
		Transfer Date ___/___/___ Transfer Time _____	
		Facility Transferred To _____	
		Transported by <input type="checkbox"/> EMS <input type="checkbox"/> Family <input type="checkbox"/> LTC Facility	
		Last Vital Signs TIME _____ BP _____ T _____ P _____ R _____ Pulse Ox _____	
		Current Height _____ Weight _____	
		Verbal Report Given by (print name/title) _____	
		Verbal Report Received by (print name/title) _____	
		Time Report Called _____	
		Signature and Title _____ Date / / Time _____	