**Transfer Form**

**Date:** Click or tap to enter a date.

**Form purpose:** Provides outline of pertinent information on individual to assist ER/Clinic visit. This is not a required document for service

**Print on BLUE paper**

**From: Facility Name:**       **Facility Address:**       **Facility Phone:**       **Facility Fax:**

**Transfer to:** **[ ]  GHS** **[ ]  MCHS** **[ ]  Other:**

**Resident Name**:       **DOB:**

**Primary Healthcare Provider:**

**Resident Emergency Contact Information:**

Name:       Phone Number:

Relationship to Resident:       Was contacted prior to transfer: [ ]  Yes [ ]  No

**Resident POA activated:** [ ]  Yes [ ]  No POA Name:       POA Contact #:

**Purpose of visit:**

**Current Vital Signs:** BP:       Pulse:       Respirations:       Temp:       O2Sat:

**Baseline Mental Status**: [ ]  Orientated [ ]  Disoriented

 Any Recent Change? (describe):

 Able to follow directions? [ ]  Yes [ ]  No Can be left alone? [ ]  Yes [ ]  No

**Usual Functional Status**: [ ]  Ambulates independently (no assistive device)

 [ ]  Ambulates independently with assistive device

 [ ]  Ambulates only with staff assistance and assistive device

**Diabetic:** **[ ]** Yes [ ]  No

**Precautions:** [ ]  No [ ]  Yes, Describe:

**Bladder Incontinence:** **[ ]** Yes [ ]  No **Bowel Incontinence:** **[ ]** Yes [ ]  No

**Belongings sent with Resident (check):** [ ]  Glasses [ ]  Dentures [ ]  Hearing aid [ ]  W/C [ ]  Portable O2 [ ]  Other:

**Call this person and/or extension when patient is ready for ER discharge or hospital admission: ­**

Name/Extension:

Phone Number­­­­­­­­­­­­­­­:

**Pharmacy Name:**       **Pharmacy Contact Information:**

**Transferring facility: send copy of** **[ ]  Advanced Directives** **[ ]  Face Sheet** **[ ]  Diagnosis List** **[ ]  POST** **[ ]  MAR**