**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**