30-Day Re-hospitalization Alert ☐

SNF to ED TRANSFER HANDOFF

Facility: ______________________________ Date: ______________________

Contact Information: ______________________________ Time: __________

Name/Title of Person Receiving Report:
Transferring Facility Name:

Patient Name: **Age/DOB**

Reason for resident transfer and any input from the sending Physician/Practitioner

Current Vital Signs: ☐ **WNL** ☐ **Abnormal**
T P R B/P
Pulse Ox: Blood Glucose:
Short Term Stay Resident ☐ Long Term Resident ☐

Physician/Provider Ordering Transfer to ED:
Name: Contact Number:

Who to Call at Facility for additional information:
Name/Title: Contact Number:

***Usual* Mental Status:**
☐ Oriented ☐ Confused ☐ Varies ☐ Calm/Cooperative ☐ Agitated

Disabilities
☐ HOH/Deaf ☐ Blind: R/L ☐ Paralysis: Upper/Lower ☐ Speech ☐ Language

Code Status: ☐ Full Code ☐ DNR *(Send Community DNR Copy to ED)*

Advance Directive Status:
Health Care Surrogate/POA: ☐ Yes ☐ No
Living Will: ☐ Yes ☐ No
Guardian: ☐ Yes ☐ No *(If Yes, send papers to ED)*

HCS/POA/Guardian Name:
Relationship to Patient:

Family Contact Aware of Transfer to ED? ☐ Yes ☐ No ☐ Attempted ☐ Uncertain

Name/Relationship: Contact Number:
Health Care Surrogate/POA/Guardian Aware of Transfer to ED? ☐ Yes ☐ No ☐ Uncertain
(Send HCS/POA/Guardian Papers to ED)

High Risk Medications:
Diabetic Agent: ☐ Yes ☐ No
Anticoagulants: ☐ Yes ☐ No
Opioids: ☐ Yes ☐ No

Antibiotic Therapy: ☐ Current ☐ Recent

Slurred Speech: ☐ New ☐ Worsened
Recent Fall: ☐ Yes ☐ No
Chest Pain: ☐ New ☐ Worsened
SOB: ☐ New ☐ Worsened
New/worsened Wound(s): ☐ Yes ☐ No
Location:

Name/Title of Person Calling Report:

Facility Contact for Patient Return:

Required Attachments: Face Sheet___ Medication Record____ DNR, (if applicable) _________

SNF CAPABILITIES LIST ON BACK

Community Version: July 30, 2017

Patient Label