

<p>A PATIENT TRANSFER AND CONTINUITY OF CARE Hospital Admission/ Discharge Dates _____</p> <p>Facility _____ Facility _____ To: _____ From: _____</p>	<p>E SOCIAL SEC. NO. _____ HEALTH INS. CLAIM _____ MEDICARE CLAIM NO. _____ MEDICAID CLAIM NO. _____ LANGUAGE _____</p>												
<p>B PATIENT'S DOB ____/____/____ SEX ____ RACE ____</p> <p>PATIENT'S LAST NAME _____ FIRST NAME _____ INITIAL _____</p> <p>PATIENT'S ADDRESS _____ APT. _____ PHONE _____</p> <p>NEAREST RELATIVE _____ PHONE _____</p> <p>PHYSICIAN INFORMATION NAME _____ PHONE _____ Will you care for Patient in NH? Yes No If not, referred to : _____</p> <p>Principle Diagnosis: _____ Secondary Diagnosis: _____ Discharge Diagnosis: _____ Surgery Performed & Date _____ MEDICATION AND TREATMENT ORDERS (copies may be attached)</p>	<p>F ADVANCED MEDICAL DIRECTIVE: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> COPY ATTACHED NAME OF SURROGATE _____</p> <p>G PHYSICAL EXAM (may attach) Heart: _____ Neck: _____ Cardiopulmonary: _____ Abdomen: _____ GU: _____ Rectal: _____ Extremities: _____ Neurological: _____ Allergy/Drug Sensitivity: _____ Free from communicable diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>												
<p>C 1. Is dementia the primary diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is there a diagnosis or presenting evidence of mental retardation, or has the client received MR services within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the client received MI services within the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there any presenting evidence of mental illness such as: (Check all that apply) ____ Schizophrenia _____ Paranoia ____ Mood _____ Panic or severe anxiety disorder ____ Somatoform disorder _____ Personality disorder ____ Other psychotic or mental disorder leading to chronic disability 4. Is the client a danger to self or others? <input type="checkbox"/> Yes - Please attach explanation <input type="checkbox"/> No 5. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. If yes, is the mental illness or psychiatric diagnosis controlled with medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>H BRIEF MEDICAL AND MENTAL HISTORY (may attach progress notes)</p> <p>MAJOR TESTS AND RESULTS</p> <p>LABORATORY FINDINGS (may attach reports) CHEST X-RAY DATE _____ RESULTS _____ C B C DATE _____ RESULTS _____ URINALYSIS DATE _____ ALBUMIN _____ SUGAR _____ ACETONE _____ TB TEST <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS _____</p>												
<p>D</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> OXYGEN LMIN _____ NASAL CANNULA _____ MASK _____ PRN _____ CONTINUOUS _____</td> <td><input type="checkbox"/> TUBE FEEDINGS FREQUENCY _____ TYPE OF FEEDING _____</td> <td><input type="checkbox"/> DRAINING WOUND CULTURED _____ DATE _____ RESULTS _____</td> </tr> <tr> <td><input type="checkbox"/> SUCTIONING FREQUENCY _____</td> <td><input type="checkbox"/> CHANGE FEEDING TUBE FREQUENCY _____</td> <td><input type="checkbox"/> DRESSING TYPE _____ FREQUENCY _____</td> </tr> <tr> <td><input type="checkbox"/> TRACH CARE FREQUENCY _____ SIZE _____</td> <td><input type="checkbox"/> CATHETER DATE LAST CHANGED _____ SIZE _____ TYPE _____</td> <td><input type="checkbox"/> DECUBITUS CARE SITE _____ SIZE _____ STAGE _____ MEDICATION/SOLUTION _____</td> </tr> <tr> <td><input type="checkbox"/> OSTOMY CARE FREQUENCY _____</td> <td><input type="checkbox"/> IRRIGATE CATHETER FREQUENCY _____ SOLUTION _____</td> <td></td> </tr> </table>	<input type="checkbox"/> OXYGEN LMIN _____ NASAL CANNULA _____ MASK _____ PRN _____ CONTINUOUS _____	<input type="checkbox"/> TUBE FEEDINGS FREQUENCY _____ TYPE OF FEEDING _____	<input type="checkbox"/> DRAINING WOUND CULTURED _____ DATE _____ RESULTS _____	<input type="checkbox"/> SUCTIONING FREQUENCY _____	<input type="checkbox"/> CHANGE FEEDING TUBE FREQUENCY _____	<input type="checkbox"/> DRESSING TYPE _____ FREQUENCY _____	<input type="checkbox"/> TRACH CARE FREQUENCY _____ SIZE _____	<input type="checkbox"/> CATHETER DATE LAST CHANGED _____ SIZE _____ TYPE _____	<input type="checkbox"/> DECUBITUS CARE SITE _____ SIZE _____ STAGE _____ MEDICATION/SOLUTION _____	<input type="checkbox"/> OSTOMY CARE FREQUENCY _____	<input type="checkbox"/> IRRIGATE CATHETER FREQUENCY _____ SOLUTION _____		<p>I TYPE OF CARE RECOMMENDED: <input type="checkbox"/> Skilled Nursing (ECF) Duration _____ <input type="checkbox"/> Intermediate Care Duration _____ Circle Rehab Potential Good Fair Poor Admission Date to Nursing Home ____/____/____ <input type="checkbox"/> I certify that this patient requires E.C.F. Nursing Home Care for the condition for which he/she received care during hospitalization. Effective Date ____/____/____</p> <p>Physician's Signature _____ Date _____ (valid for both pages)</p> <p>PRINT PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NUMBER _____ <small>Federal law mandates the physician's signature; all other signatures on this form are optional.</small></p>
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