



Change statute 400.452 to 429.52.

PATIENT TRANSFER AND CONTINUITY OF CARE

Facility To: Facility From: Hospital Admission/Discharge Dates

Social Sec. No.: Health Ins. Claim No.: Medicare Claim No.: Medicaid Claim No.: Language:

Patient's DOB: Sex: Race: Patient's Last Name First Name Initial Patient's Address Phone Nearest Relative Phone

ADVANCED MEDICAL DIRECTIVE: Yes No Copy Attached Name of Surrogate:

PHYSICIAN INFORMATION: Name: Phone: Will you care for Patient in NH? Yes No If not, referred to:

PHYSICAL EXAM (may attach) Heart: Neck: Cardiopulmonary: Abdomen: Gu: Rectal: Extremities: Neurological: Allergy/Drug Sensitivity: Free from communicable diseases? Yes No

Principle Diagnosis: Secondary Diagnosis: Discharge Diagnosis: Surgery Performed & Date:

BRIEF MEDICAL AND MENTAL HISTORY (may attach progress notes)

MEDICATION AND TREATMENT ORDERS (copies may be attached): Immunizations Given: Pneumococcal Vaccine; Date: Influenza Vaccine; Date:

MAJOR TESTS AND RESULTS:

1. Is dementia the primary diagnosis? 2. Is there a diagnosis or presenting evidence of mental retardation... 3. Has the client received MI services... 4. Is the client a danger to self or others? 5. Is the client on any medication... 6. If yes, is the mental illness or psychiatric diagnosis controlled with medication?

LABORATORY FINDINGS: (may attach reports) Chest X-Ray: Date: Results: C B C: Date: Results: Urinalysis: Date: Albumin: Sugar: Acetone: TB Test: Yes No Results:

OXYGEN: Tube Feeding: Draining Wound: Suctioning: Change Feeding Tube: Dressing: Trach Care: Catheter: Decubitus Care: Ostomy Care: Irrigate Catheter:

TYPE OF CARE RECOMMENDED: Skilled Nursing (ECF): Intermediate Care: Rehab Potential (check one): I certify that this patient requires E.C.F. Nursing Home Care... Effective Date: Physician's Signature (valid for both pages) Date Print Physician's Name Address Phone Number Federal law mandates the physician's signature; all other signatures on this form are optional.