SCAT | STILLWATER COMMUNITY ACTION TEAM

# Community Resident/Patient
# Continuum of Care Transfer Form

Transfer to ER from: ____________________

Home ☐ Assisted Living ☐ Skilled ☐ Long Term ☐ Full Code ☐ DNR consent ☐

Patient Name: ____________________ DOB: ____________

**Reason for Transfer:** ____________________

Emergency ☐ Non-Emergency ☐ Physician Certification Statement ☐

Hospitalized with in the last 30 days: Yes ☐ No ☐ Reason: ____________

Diagnosis: ____________________

Allergies (medications, dyes, food) ____________________

Primary Care Physician: ____________________

Relative / Guardian Notified: Yes ☐ No ☐

Name of Relative: ____________________ Phone: ____________

Patient on Home Health/ Hospice Yes ☐ No ☐ Company/Nurse: ____________

Has Home Health/ Hospice Notified: Yes ☐ No ☐ Phone: ____________

**Attachments: please check**

- __ Face sheet
- __ MAR
- __ Advance Directives
- __ POA
- __ DNR consent
- __ History & Physical
- __Other

**Vital Statistics Taken:**

| | | | |
|---|---|---|---|
| Time taken: | Weight: Date: | |
| Respirations: $O_2$ Sat: | Height: | |
| Pulse: BP: | **VRE:** Yes ☐ No ☐ Hx of ☐ N/A ☐ | **Site of infection:** |
| Temp: | **MRSA**: Yes ☐ No ☐ Hx of ☐ N/A ☐ | |
| Blood Glucose: Time: | **CDIFF** Yes ☐ No ☐ Hx of ☐ N/A ☐ | |
| Level on Pain Scale at time of transfer (please circle level number) **0 1 2 3 4 5 6 7 8 9 10** | | **Location:** |

**************************** YOUR SPECIAL ATTENTION PLEASE ************************************

**High risk for skin breakdown Yes** ☐ No ☐ **Potential or previous pressure points** ____________

**Current Skin Breakdown**: No ☐ Yes ☐ Where: ____________________ (See tx sheet attached)

Vaccination History**: Pneumococcal Vaccine**: Yes ☐ date ____________ Refused ☐ Unknown ☐

**Flu Vaccine:** Yes ☐ date ____________ Refused ☐ Unknown ☐ **Tetanus**: Yes ☐ date: ________ Unknown ☐

**Activity:** ☐ Independent ☐ One person assist ☐ Two person assist ☐ Standby assist ☐ Walker ☐ Cane
☐ Min assist ☐ Mod assist ☐ Max assist ☐ Total assist ☐ Immobile

**Meds**: ☐ Whole ☐ Crushed Prefers meds with: ____________ **Safety Concerns**: ____________

**Behavior Problems:** ____________ **Hx of Falls**: No ☐ Yes ☐ **Risk For Falls:** No ☐ Yes ☐

Restraints: No ☐ Yes ☐ Type used: ____________ When used ____________

**Current Diet**: ____________________

- ☐ Needs Assistance ☐ Feeds Self
- ☐ Thickened Liquid Consistency needed ______
- ☐ Feeding Tube ____________
- ☐ Supplement

**Elimination:**

- ☐ Bladder Incontinence **Date** of UTI ________ within 14 days
- ☐ Bowel Incontinence **Date** of last BM ____________
- ☐ Catheter **Date** inserted or last changed ____________
- ☐ Colostomy

**Impairments / Disabilities: (Please check all that apply)**

☐ Speech ☐ Contractures ☐ Mental Confusion ☐ Language Barrier
☐ Hearing ☐ Amputation ☐ Paralysis ☐ Vision ☐ Other ____________

**Baseline Mental/Neuro Status: (Please check all that apply)**

☐ Oriented x 4 ☐ Not oriented to person ☐ Not oriented to place ☐ Not oriented to time ☐ Not oriented to situation
☐ Forgetful ☐ Non verbal ☐ Inappropriate speech ☐ Right sided weakness ☐ Left sided weakness

Comments: ____________________

**Nurse or Associate sending to ER:** ____________________ **Phone:** ____________

Call report to: Nurse ____________________ Phone: ____________