

RESIDENTIAL AGED CARE FACILITY TRANSFER/DISCHARGE SUMMARY

Transfer To		Transfer From	
Facility/Hospital:		Facility/Hospital:	
High Care <input type="checkbox"/> Low Care <input type="checkbox"/> ED <input type="checkbox"/>		High Care <input type="checkbox"/> Low Care <input type="checkbox"/> ED <input type="checkbox"/> Ward	
Facility/Hospital Notified of Transfer: No <input type="checkbox"/> Yes <input type="checkbox"/>		Phone:	
Person contacted:		Fax:	
Personal Details			
Name:		Preferred Name:	MRN:
Marital Status: M <input type="checkbox"/> W <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/>		Gender: M <input type="checkbox"/> F <input type="checkbox"/>	
Date of Birth:		Medicare No.	Expiry Date:
Country of Birth:		Pension No.	DVA No. Colour:
Religion:		Language Spoken:	Interpreter? No <input type="checkbox"/> Yes <input type="checkbox"/>
Private Health Insurance? No <input type="checkbox"/> Yes <input type="checkbox"/> - Health Fund Name & No:			
Nominated Medical Practitioner (GP)			
Dr.:		Ph:	Fax: Aware of transfer: No <input type="checkbox"/> Yes <input type="checkbox"/>
Emergency Contacts / Persons Responsible			
Name:		Relationship:	Guardian <input type="checkbox"/> POA <input type="checkbox"/> - Enduring <input type="checkbox"/>
Ph: (H)		(W)	(M) Aware of transfer? No <input type="checkbox"/> Yes <input type="checkbox"/>
Name:		Relationship:	Guardian <input type="checkbox"/> POA <input type="checkbox"/> - Enduring <input type="checkbox"/>
Ph: (H)		(W)	(M) Aware of transfer? No <input type="checkbox"/> Yes <input type="checkbox"/>
Reason for Transfer/Progress in Hospital		Relevant History/Investigations (attach reports)	
Nursing Diagnosis:		Infectious diseases: No <input type="checkbox"/> Yes <input type="checkbox"/> (give details)	
Current Medications/Complementary Therapies			
Safe to self medicate? no <input type="checkbox"/> yes <input type="checkbox"/> - bottles / boxes <input type="checkbox"/> multi-dose packaging <input type="checkbox"/>			
Special needs of this person e.g. crush medications <input type="checkbox"/>			
Name / Phone /Fax of preferred Pharmacy:			
* Attach copy of current medication chart/s			
* Fax prescriptions to RACF preferred pharmacy by 12 noon on the day of discharge			
Allergies / Reactions			
Observations Prior to Transfer			
BP	P	T	R Urinalysis BSL (if appropriate)
Communication/Sensory (tick appropriate observation/s)			
Communication:		normal <input type="checkbox"/>	follows directions <input type="checkbox"/> responds to non-verbals <input type="checkbox"/>
		unintelligible <input type="checkbox"/>	expressive impairment <input type="checkbox"/> receptive impairment <input type="checkbox"/>
Speech:		normal <input type="checkbox"/>	impaired <input type="checkbox"/>
Vision:		normal <input type="checkbox"/>	impaired <input type="checkbox"/> blind <input type="checkbox"/> artificial eye <input type="checkbox"/> Glasses <input type="checkbox"/> - with patient: <input type="checkbox"/>
Hearing:		normal <input type="checkbox"/>	impaired <input type="checkbox"/> Deaf <input type="checkbox"/> Aid/s: right <input type="checkbox"/> left <input type="checkbox"/> - with patient <input type="checkbox"/>

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Mobility / Transfers	
Mobility:	independent <input type="checkbox"/> chair/bed bound <input type="checkbox"/> requires assistance <input type="checkbox"/> - no. of staff required
Aids used:	walking stick/s <input type="checkbox"/> frame <input type="checkbox"/> wheelchair <input type="checkbox"/> prosthesis <input type="checkbox"/>
Transfers:	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - no. of staff required
Aids used:	slide sheet <input type="checkbox"/> transfer belt <input type="checkbox"/> lifter <input type="checkbox"/> - type:
Falls history:	no <input type="checkbox"/> yes <input type="checkbox"/> Safety requirements:
Dietary Needs / Meals & Drinks	
Diet:	normal <input type="checkbox"/> diabetic <input type="checkbox"/> salt reduced <input type="checkbox"/> lactose free <input type="checkbox"/> enteral/PEG <input type="checkbox"/>
	minced <input type="checkbox"/> cut-up <input type="checkbox"/> puree <input type="checkbox"/> Time last intake
Fluids:	thin <input type="checkbox"/> thickened <input type="checkbox"/> - stage 1 <input type="checkbox"/> stage 2 <input type="checkbox"/>
Feeding:	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - minimal <input type="checkbox"/> moderate <input type="checkbox"/> maximum <input type="checkbox"/>
Personal Care/Oral Care	
P/care:	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - min <input type="checkbox"/> mod <input type="checkbox"/> max <input type="checkbox"/> - no. of staff required
Skin:	intact <input type="checkbox"/> at risk <input type="checkbox"/> broken <input type="checkbox"/> - sites:
Teeth:	own – upper <input type="checkbox"/> lower <input type="checkbox"/> Dentures: Partial - upper <input type="checkbox"/> lower <input type="checkbox"/> Full - upper <input type="checkbox"/> lower <input type="checkbox"/>
Toileting/Continance	
Toileting:	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - min <input type="checkbox"/> mod <input type="checkbox"/> max <input type="checkbox"/> no. of staff required
Bladder:	continent <input type="checkbox"/> incontinent <input type="checkbox"/> frequency <input type="checkbox"/> urgency <input type="checkbox"/> stress <input type="checkbox"/> nocturia <input type="checkbox"/>
	IDC <input type="checkbox"/> SPC <input type="checkbox"/> - Date inserted/changed: size type
Bowels:	continent <input type="checkbox"/> incontinent <input type="checkbox"/> colostomy <input type="checkbox"/> ileostomy <input type="checkbox"/> last opened:
Aids/Strategies used:
Neurological / Behaviour	
Conscious state:	alert <input type="checkbox"/> drowsy <input type="checkbox"/> varies <input type="checkbox"/> Mood: normal <input type="checkbox"/> agitated <input type="checkbox"/> flat <input type="checkbox"/>
Memory:	normal <input type="checkbox"/> short term memory loss <input type="checkbox"/> Hx dementia <input type="checkbox"/> delirium/memory fluctuates <input type="checkbox"/> MMSE:
Behaviours:	nil known <input type="checkbox"/> wandering/intrusive <input type="checkbox"/> verbally disruptive <input type="checkbox"/> repetitive actions <input type="checkbox"/>
	physically aggressive <input type="checkbox"/> resistive to care <input type="checkbox"/> other <input type="checkbox"/>
Strategies:
Pain	Sleep
Chronic pain: Yes <input type="checkbox"/> No <input type="checkbox"/> New pain: Yes <input type="checkbox"/> No <input type="checkbox"/>	Usual routine
Location:
Management:	Wakes & wanders <input type="checkbox"/>
Lifestyle Choices	
Smoker	No <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Yes <input type="checkbox"/> - years smoked amount/day
Alcohol	No <input type="checkbox"/> Ex-drinker <input type="checkbox"/> Yes <input type="checkbox"/> - standard drinks/day
Advance Care Directive / Advance Care Plan	
Does the patient have an advanced care directive/plan? No <input type="checkbox"/> Yes <input type="checkbox"/> - (attach copy)	
Documents/Personal Items Sent with Patient	
Medication charts <input type="checkbox"/> Clinical letters <input type="checkbox"/> X-Rays <input type="checkbox"/> Pathology reports <input type="checkbox"/> Hearing aids <input type="checkbox"/> Glasses <input type="checkbox"/>	
Dentures <input type="checkbox"/> Clothes <input type="checkbox"/> Toiletries <input type="checkbox"/> Valuables <input type="checkbox"/> Other <input type="checkbox"/>	
Ongoing Nursing/Wound Management / Other Comments:	
Handover & form completed by:	
Print:	
Date:	