

## NURSING TRANSFER FORM

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. ....
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) .....
Name: .....		Relationship: .....	Guardian <input type="checkbox"/> POA <input type="checkbox"/> - Enduring <input type="checkbox"/>
Ph: (H) .....		(W) .....	(M) .....
Reason for Transfer/Progress in Hospital		Relevant History/Investigations (attach reports)	
Infectious diseases: No <input type="checkbox"/> Yes <input type="checkbox"/> (give details)			
Current Medications/Complementary Therapies (RACF to be sent 3 days supply of medications on discharge)			
Safe to self medicate? no <input type="checkbox"/> yes <input type="checkbox"/> - bottles/boxes <input type="checkbox"/> multidose package <input type="checkbox"/> Medication chart/s attached <input type="checkbox"/>			
Special needs of this person e.g. crush medications <input type="checkbox"/> .....			
Allergies / Reactions			
Observations Prior to Transfer			
BP	P	T	R
Urinalysis			BSL (if appropriate)
Communication/Sensory (tick appropriate observation/s)			
<b>Communication:</b>		normal <input type="checkbox"/>	follows directions <input type="checkbox"/>
		unintelligible <input type="checkbox"/>	expressive impairment <input type="checkbox"/>
			receptive impairment <input type="checkbox"/>
<b>Speech:</b>		normal <input type="checkbox"/>	impaired <input type="checkbox"/>
<b>Vision:</b>		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"/>
<b>Hearing:</b>		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"/>

## NURSING TRANSFER FORM

Mobility / Transfers	
<b>Mobility:</b>	independent <input type="checkbox"/> chair/bed bound <input type="checkbox"/> requires assistance <input type="checkbox"/> - no. of staff required .....
<b>Aids used:</b>	walking stick/s <input type="checkbox"/> frame <input type="checkbox"/> ..... wheelchair <input type="checkbox"/> prosthesis <input type="checkbox"/> .....
<b>Transfers:</b>	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - no. of staff required .....
<b>Aids used:</b>	slide sheet <input type="checkbox"/> transfer belt <input type="checkbox"/> lifter <input type="checkbox"/> - type: .....
<b>Falls history:</b>	no <input type="checkbox"/> yes <input type="checkbox"/> <b>Safety requirements:</b> .....
Dietary Needs / Meals & Drinks	
<b>Diet:</b>	normal <input type="checkbox"/> diabetic <input type="checkbox"/> salt reduced <input type="checkbox"/> lactose free <input type="checkbox"/> enteral <input type="checkbox"/> .....
	minced <input type="checkbox"/> cut-up <input type="checkbox"/> puree <input type="checkbox"/> <b>Time last intake</b> .....
<b>Fluids:</b>	thin <input type="checkbox"/> thickened <input type="checkbox"/> - stage 1 <input type="checkbox"/> stage 2 <input type="checkbox"/>
<b>Feeding:</b>	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	
<b>P/care:</b>	independent <input type="checkbox"/> requires assistance <input type="checkbox"/> - min <input type="checkbox"/> mod <input type="checkbox"/> max <input type="checkbox"/>
<b>Skin:</b>	intact <input type="checkbox"/> at risk <input type="checkbox"/> broken <input type="checkbox"/> .....
<b>Teeth:</b>	own – upper <input type="checkbox"/> lower <input type="checkbox"/> <b>Dentures:</b> Partial - upper <input type="checkbox"/> lower <input type="checkbox"/> Full - upper <input type="checkbox"/> lower <input type="checkbox"/>
Toileting/Contenance	
<b>Toileting:</b>	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 .....
<b>Bladder:</b>	continent <input type="checkbox"/> incontinent <input type="checkbox"/> frequency <input type="checkbox"/> urgency <input type="checkbox"/> stress <input type="checkbox"/> nocturia <input type="checkbox"/>
	ileostomy <input type="checkbox"/> IDC <input type="checkbox"/> SPC <input type="checkbox"/> - Date inserted: ..... size ..... type .....
<b>Bowels:</b>	continent <input type="checkbox"/> incontinent <input type="checkbox"/> colostomy <input type="checkbox"/> last opened .....
<b>Aids/Strategies used:</b>	.....
Neurological / Behaviour	
<b>Conscious state:</b>	alert <input type="checkbox"/> drowsy <input type="checkbox"/> varies <input type="checkbox"/> <b>Mood:</b> normal <input type="checkbox"/> agitated <input type="checkbox"/> flat <input type="checkbox"/>
<b>Memory:</b>	normal <input type="checkbox"/> short term problems <input type="checkbox"/> confused state <input type="checkbox"/> <b>MMSE:</b> .....
<b>Behaviours:</b>	nil known <input type="checkbox"/> wandering/intrusive <input type="checkbox"/> verbally disruptive <input type="checkbox"/> repetitive actions <input type="checkbox"/>
	cooperative <input type="checkbox"/> physically aggressive <input type="checkbox"/> resistive to care <input type="checkbox"/> other <input type="checkbox"/> .....
<b>Strategies:</b>	.....
<b>Pain</b>	<b>Sleep</b>
	Usual routine .....
	Wakes & wanders <input type="checkbox"/>
Lifestyle Choices	
<b>Smoker</b>	No <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Yes <input type="checkbox"/> - years smoked ..... amount/day .....
<b>Alcohol</b>	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"/> .....	
<b>Ongoing Nursing Management / Other Comments:</b>	
<b>Handover &amp; form completed by:</b>	<b>Print:</b>
	<b>Date:</b>