Facility Transfer Face Sheet and Checklist from AFH

AFH: _____
Provider: _____
Phone #: _____

Resident Name: _____
Date of Birth: _____
Medical Insurance Medicare #: _____
Other insurance: _____
#: _____
Primary Care Provider_____
Phone #: _____ Fax #: _____

Healthcare POA: _____
Phone #: _____
Alternative POA/Family Member: _____
Phone #: _____

Preferred Hospital: _____
Current Pharmacy: _____
Phone #: _____ Fax #: _____

ALLERGIES REACTIONS TO ALLERGIES

CODE STATUS
- □ **Full code**
- □ **DNAR**
- □ **Unknown**

Diet:
- □ **Dysphagia**

Baseline Mobility Status
- □ **Ambulatory**
- □ **Ambulatory w/asst**
- □ **Ambulatory w/devices**
- □ **Non Ambulatory**
- □ **History of Falls**

Communication Deficits
- □ **Hearing**
- □ **Sight**
- □ **Aphasia**

Reason for Transfer/Need for Evaluation
(Include fall(s); changes in behavior, respiratory, GI, neurological, cardiac, GU/urinary status, uncontrolled pain; recent medication changes, functional/mobility changes.)

Personal Effects Sent: □ Dentures □ Glasses □ Hearing Aids

Relevant Diagnoses:
☐CHF ☐Respiratory ☐Chronic Renal Failure ☐Diabetes ☐Cancer (active treatment)
☐Dementia Type _____ ☐Other _____

USUAL Mental Status:
☐Alert and oriented ☐Alert, disoriented but can follow simple instructions
☐Alert, disoriented, cannot follow simple instructions ☐Not Alert
☐Comment on baseline behaviors (hallucinations, wandering, exit seeking, STM loss, sundowning)

ATTACHED RECORDS:
☐ Medical Diagnosis List ☐ **GREEN *COPY*** OF POLST
☐ Current copy of MAR ☐ Last hospital discharge summary if available
☐ Copy Release of Information signed by POA