Island Health COMPLEX CARE Resident ED Transfer Form

Instructions for Use:

1. *The purpose of this form is to facilitate communication between Emergency Department (ED) and Long-term Care (LTC) homes during transfers.*
2. *The top part of the sheet is filled out by the LTC facility before sending resident to ED after applying **PINK BAND***
3. ***The bottom part of the sheet is filled out by the ED before transferring back to the Residential Care Facility.***
4. *The sending facility must give a verbal report to the receiving facility before transfer, using IDRAW.*

Stamp Here or write in Resident's name and PHN

Transfer to: _____ Date: _____ Transfer from: _____ Phone: _____ Local: _____

Most Responsible Physician: _____ Was MRP Notified? Yes ☐ No ☐

Contact Person: _____ Relationship: _____ Phone: _____ Was Contact Person Notified? Yes ☐ No ☐

Reason for Transfer:
Medical History & Diagnosis:
Date of Last Medical Assessment:
Allergies:
Vitals: BP: P: T: R:

Advance Directives? Yes ☐ *(Include Copy)* **MOST?** Yes ☐ *(Include Copy)*

Infection Control? Yes ☐ No ☐

Activities of Daily Living Prior to Transfer			
	Self	*Assist*	*Dependent*
Wash/Dress			
Eating			
Transfer			
Toileting			
Ambulation			

Patient Medication Profile: *See Attached*
Include time and date of last dose

Cognition: ☐ Intact
☐ Impaired → ☐ *Needs Reminders* ☐ *Needs Direction* ☐ *Totally Dependent*

Is resident Continent? Bowel ☐ Yes ☐ No Last BM: _____ Bladder ☐ Yes ☐ No

Diet: _____

Swallowing difficulties? ☐ Yes ☐ No **Dentures?** ☐ Yes ☐ No

Sight *(with corrective devices if needed)*: Poor Fair Good **Glasses?** ☐ Yes ☐ No

Hearing *(with corrective devices if needed)*: Poor Fair Good **Hearing Aids?** ☐ Yes ☐ No

Is resident a smoker? ☐ Yes ☐ No

Safety/Behavioral Concerns/Special Needs: _____

Violence Alert / History: _____ Restraints/Treatments/Skin/Pressure Injuries: _____

Receiving facility notified? ☐ Yes ☐ No **IDRAW verbal given to:** _____ _____

Signature

This section to be completed by ED nurses prior to transfer to LTC Facility

Diagnosis _____

Last BM: _____

Treatments/interventions while in ER: _____

Last Vital Signs Time: _____ BP: _____ P: _____ R: _____ T: _____ **MOST?** Yes ☐ *(Include Copy)*

Medications received while in ER: _____

Copy of latest MAR ☐

Follow up instructions/consults/referrals: _____

Prescription sent? ☐ Yes ☐ No

Receiving facility notified? ☐ Yes ☐ No **IDRAW Report** _____

Signature

Please photocopy and keep on resident's chart