HOSPITAL TO HOME CARE HANDOFF COMMUNICATION

Hospital		Home Care Provider	Phone
Patient Care Unit	Phone	Home Care Physician	Phone
Discharging Physician	Phone ☐	Primary Care Physician	Phone

Patient Name (Last, First, MI)	Date of Birth	Sex	Social Security Number

Admission Date___/___/___ Reason for hospitalization_____

CODE STATUS ☐ See DNR Form
☐ Full ☐ Limited ☐ DNR

ALLERGIES ☐ No Known Allergies ☐ See MAR

☐ Durable Power of Attorney for Health Care ☐ Guardian
Name Phone

☐ Health Care Decision Maker or Local Contact Notified of Transfer
Name Phone

Advance Directives ☐ Yes ☐ No

Resident able to make own decisions ☐ Yes ☐ No

Speaks English ☐ Yes ☐ No If no, specify

Religious/Literacy Concerns ☐ None

Admissions to Other Hospitals/Facilities in Past Month ☐ None

Chronic Conditions ☐ See Diagnosis Sheet

Immunizations ☐ None ☐ Influenza___/___/___ ☐ Pneumonia ___/___/___ ☐ Tetanus___/___/___ ☐ TB Skin Test___/___/___

CHECK ALL THAT APPLY

Mental Status ☐ Alert ☐ Oriented ☐ Non-Verbal ☐ Unresponsive ☐ Confused ☐ Uncooperative ☐ Disruptive ☐ Withdrawn ☐ Depressed

Impairments	☐ Mental (describe)	☐ Speech (describe)	☐ Hearing (describe)	☐ Vision (describe)	☐ Sensation (describe)

Disabilities	☐ Amputation (describe)	☐ Prosthesis (describe)	☐ Contracture (describe)	☐ Paralysis (describe)

Mobility ☐ No Mobility Aids ☐ Cane ☐ Walker ☐ W/C ☐ Bed Bound ☐ No Weight Bearing ☐ Partial Weight Bearing ____ Leg

Falls Last 30 Days ☐ No ☐ Yes ___/___/___ ___/___/___ Injury ☐ No ☐ Yes (describe)_____

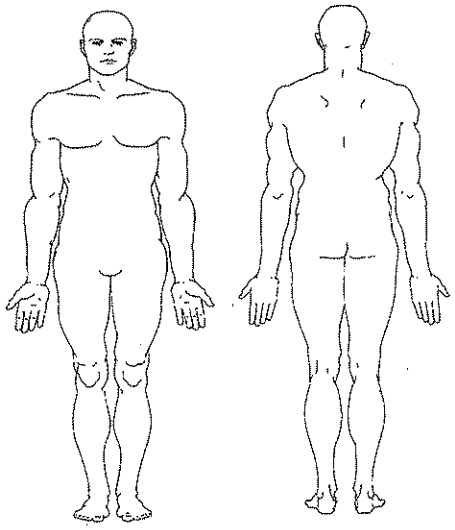
Infection ☐ MRSA Site ☐ VRE Site ☐ C. difficile ☐ UTI ☐ Other

Elimination Last BM___/___/___ Urinary Cath. In Past Month ☐ Yes ☐ No Inserted/Changed___/___/___ Discontinued___/___/___

Records Sent or Faxed ☐ Face Sheet ☐ H&P ☐ Medication Administration Record (Current) ☐ Physician Order Sheet (Most Recent)
☐ Last Nursing Assessment ☐ Current Lab & Radiology Report ☐ This Form ☐ Advance Directives/ DPOA ☐ DNR Form ☐ Diagnosis Sheet

Belongings Sent With Resident ☐ None ☐ Eyeglasses/Contacts ☐ Dentures/Partial Plates ☐ Upper ☐ Lower ☐ Both
☐ Hearing Aid(s) ☐ L ☐ R ☐ Cane ☐ Walker ☐ Splint ☐ Brace ☐ Wound Vac ☐ Jewelry (list)_____

Skin and Body Assessment ☐ Skin Intact ☐ Skin Not Intact—Identify each area with a number on the diagram and describe site & care in notes below.



#1 Site_____
Care_____
#2 Site_____
Care_____
#3 Site_____
Care_____

Discharge Date ___/___/___ Discharge Time _____

Transported by: EMS Family Self

Last Vital Signs TIME_____ BP _____ T _____ P _____ R _____ Pulse Ox _____

Current Height _____ Weight _____

Verbal Report Given by (print name/title) _____

Verbal Report Received by (print name/title)_____

Time Report Called _____

Signature and Title_____ Date ___/___/___ Time___