Hospital to Home Alliance of Ventura County

ACUTE TO SNF Transfer Form (Nursing Hand-off)

Resident Name:_____

Admission Report: Date/Time: _____
SNF Attending MD_____
Admitted From [ ] Hospital [ ]Home [ ]MD Office [ ]Clinic
Discharging Hospital: _____

Advance Directive [ ] Yes [ ] No
Resident Representative/Responsible Party____
Code Status:_____**[ ] Full Code [ ] DNR [ ] POLST [ ] NO POLST**
Palliative Care Consult while hospitalized? [ ] Yes [ ] No

Hospital Nurse Giving Report _____

Phone# of Unit_____

Nurse Receiving Report_____

Allergies: _____
Pertinent Labs: _____

Consults/Follow-ups: _____
Pending Labs:_____

Diagnoses	1.	5.
	2.	6.
	3.	7.
	4.	8.
Vital Signs	B/P:	**Pain:**
	Pulse:	Location of Pain:
	Respirations:	Level of Pain:
	Temperature:	Medicated prior to transfer: [ ]Yes [ ] No
Mental Status	Oriented x1 [ ]	Oriented x3 [ ]
	Oriented x2 [ ]	Oriented x4 [ ]
	Behavioral Issues:	Psychotropics? [ ] Yes [ ] No
Isolation:	[ ] Yes [ ] No	**Immunization:**
	Contact [ ]	Flu Vaccine given? [ ] Yes When:_____ [ ] No
	Respiratory [ ]	PREV13 vaccine given? [ ] Yes When:_____ [ ] No
	Micro-organism?_____	PREV23 vaccine given? [ ] Yes When:_____ [ ] No

Respiratory/ Lung Sounds Treatments	[ ]Normal [ ]Wheezing [ ]Rales/Rhonchi [ ]Cough [ ]SOB	Oxygen Use: [ ] Yes [ ] No
	Nebulizer Treatment:_____ Suction:_____	Continuous [ ] or PRN [ ] liters per minute via _____
	Most recent O2 Sat?_____	BiPAP [ ] Yes [ ] No CPAP [ ] Yes [ ] No Settings: _____
Cardiovascular	Pacemaker [ ] Yes [ ] No	**Gastrointestinal:**
	[ ] Non-pitting edema	Bowel Sounds Present [ ] Yes [ ] No
	[ ] Pitting Edema +_____	Last BM_____
	Latest Weight:_____Date Taken:_____	Diarrhea: [ ] Yes [ ] No
	Method: [ ] Chair [ ] Bed [ ] Standing	Constipation: [ ] Yes [ ] No
Diet	[ ]Reg [ ] Mech Soft [ ] Puree [ ] chopped [ ] NAS [ ] NCS	Liquids: [ ] Thin [ ] Nectar [ ] Honey
	Difficulty Swallowing [ ] Yes [ ] No	TPN [ ] Yes [ ] No
	Fluid Restriction [ ] Yes [ ] No	GT/NGT [ ] Yes [ ] No Formula_____
Musculo-skeletal	[ ] Steady Gait [ ] Unsteady Gait/Poor Balance	**Transfer Assistance:** [ ] Independent
	Weight Bearing Status: [ ] WBAT [ ] TTWB [ ] NWB	[ ] Supervision
	CPM:	[ ] Limited Assistance
	Immobilizers/Splints:	[ ] Extensive Assistance
	Cast:	[ ] Total Dependence
Genitourinary	[ ] Burning Urination [ ] Distention/Retention	[ ] Urostomy
	[ ] Frequency/Urgency [ ] Hematuria	[ ] Nephrostomy tube
	[ ] Indwelling Catheter [ ] Suprapubic Catheter	[ ] External Catheter
	Catheter Diagnosis:_____	Latest Output:_____
Skin	[ ] Rash/Itching	[ ] Surgical Wounds
	[ ] Pressure Ulcers	Location of Wounds_____
	Location and Stage of Pressure Ulcers: _____	Treatments:_____ _____
	[ ] LAL Mattress [ ] APP Mattress	[ ] Negative Wound Pressure Therapy
Toileting;	Uses the toilet [ ] Yes [ ] No	Uses a bedpan [ ] Yes [ ] No
	Uses a Urinal [ ] Yes [ ] No	[ ] Continent: [ ] Bowel [ ] Bladder [ ] Incontinent: [ ] Bowel [ ] Bladder
	Intravenous Medication [ ] Yes [ ] No	IV Dressing Change Due:
Antibiotic Treatment	IV Antibiotic_____ Time next dose due: _____	PICC Line [ ] Yes [ ] No Site:_____#lumen_____
	PO Antibiotic_____ Time next dose due:_____	IV Gauge:_____Site: _____
	Indication:_____	
Dialysis	Schedule:	
	Dialysis Center:	
	Access Site:	
COVID Information:	**TYPE OF TEST PERFORMED**_____	**TYPE OF TEST PERFORMED**_____
	COVID TEST RESULT/S: _____ **DATE OF TESTING/S:** _____	**COVID TEST RESULT/S:** _____ **DATE OF TESTING/S:** _____
	LAST EXPOSURE TO A COVID+ INDIVIDUAL: _____	