Alberta Health Services

Patient Information Transfer

Patient Label

Transfer	Date (yyyy-Mon-dd)	from ☐ LTC ☐ SL4 ☐ SL4D ☐ PAL ☐ PCH ☐ other site:

Name of Centre	Unit	Staff Name (who is filling in form) ☐LPN ☐RN ☐NP ☐other:	Direct Phone Local	Fax

Reason(s) for Transfer / Assessment / Intervention(s) (e.g. further assessment, diagnostics, escalating behaviours, family request). If patient is designated as C1 or C2, state the primary reason for transfer (e.g. patient/family request, pain and symptom management)

☐ Attach patient's medical history

COVID-19 Status ☐ Positive ☐ Negative ☐ Unknown COVID-19 Swab pending: ☐ Yes ☐ No Swab Date:_____

If COVID-19 Positive, is it a Variant of Concern(VOC) ☐ Yes Variant: _____ ☐ No ☐ Unknown

Sending Facility on COVID-19 outbreak ☐ Yes ☐ No ☐ Under investigation

Allergies and reactions ☐ Attached in Medication Administration Record ☐ Unknown

Vital signs	Time (hh:mm)	Temp	B/P	HR	Resps	O_2 Sats Home O_2/Flow: Current O_2/Flow:	Weight	*POCT Glucose Time: Level:

Please send Green Sleeve containing the following required documents (check box if sent)

☐ Goals of care (GOC) designated order form – COPY (keep original in Resident's chart)
☐ Tracking record for GOC discussions – COPY (keep original in Resident's chart)
☐ Medication Administration Record
☐ Personal Directive – COPY (keep original in Resident's chart)

Is the facility/unit on outbreak for a reason other than COVID - 19?
☐ yes ☐ no

Are there barriers to the client returning if there is no medical need to admit to the hospital?
☐ yes ☐ no - if yes, describe:

Behaviours & safety issues:
☐ Attached behaviour mapping
☐ History of aggression – provide strategies to de-escalate
☐ Fall risk
☐ Wanders

Describe and provide strategies to de-escalate:

Baseline cognitive status
☐ Alert/Oriented
☐ Mild dementia or other cognitive impairment
☐ Moderate to severe dementia or other cognitive impairment

Any recent change(s) in cognitive status?
If so, what has changed and when was the onset?

Baseline functional status
Ambulatory ☐ yes ☐ no
Transfer ☐ independent ☐ standby ☐ 1 person assist ☐ 2 person assist ☐ mechanical lift

Patient language (if not English):

Attending Physician: Phone:

Primary contact	Name ☐ next of kin ☐ guardian/agent (if enacted PD)	Phone number	Relationship	Notified of transfer? ☐ yes ☐ no

Notified Transition Services if destination known? ☐yes ☐no
Transition Services Contacted (circle): RGH 403-943-3204 PLC 403-943-5434 FMC 403-944-1231 SHC 403-956-3021

Continued (must complete) ➔ Page 1 Side A

Skin / wound protocol ☐ yes ☐ no

Specialty Mattress ☐ yes ☐ no

Elimination ☐ Independent ☐ Continent

☐ Incontinent Bladder

☐ Incontinent Bowel

☐ Catheter: Date Changed_____ Size _____

☐ Ostomy Last B.M. _____ Last Void _____

Nutrition

☐ aspiration risk

☐ swallowing precautions

☐ enteral tube feed/ NPO

☐ assistance required

Diet type:

☐ Regular

☐ Diabetic

☐ Other:

Belongings SENT and RETURNED (check/circle)

Walking aid required	no	yes	sent	**returned**
Vision ☐ normal ☐ impaired ☐ blind ☐ glasses	no	yes	sent	**returned**
Hearing device	no	yes	sent	**returned**
Dentures	no	yes	sent	**returned**
Wanderguard	no	yes	sent	**returned**
other:	no	yes	sent	**returned**
other:	no	yes	sent	**returned**

ED Circle

Emergency Department Nurse discharge checklist

☐RGH ☐FMC ☐PLC ☐SHC ☐Rural ☐Other Site:_____

☐ Attach Discharge Summary - if not available, ask ED Physician to complete this section including details on new medications, suggested medication changes and if **follow up is required.**

☐ Attach ED UCC Visit Summary

☐ Photocopy and attach any Specialist handwritten consult notes

☐ Attach eMAR or

☐ Attach or list dose, time and medications given by ED

Patient COVID-19 Status: ☐ Positive ☐ Negative ☐ Unknown If COVID-19 Positive, VOC ☐Yes ☐ No ☐ Unknown

COVID-19 Swab pending: ☐ Yes ☐ No Swab Date:_____

☐ For new prescriptions, attach prescription(s) to Discharge Summary

☐ List any bridging medication sent with patient:

Verbal report given to Centre?

☐ yes

☐ no, explain:

Name of person that GAVE report (if different than completing this section)

☐LPN ☐RN ☐NP ☐MD

Name of person receiving report:

☐LPN ☐RN ☐NP ☐other:

☐ I have reviewed the new and/or changed treatment plan with the resident's site in the interests of safe care.
(Medications/supplies/equipment (like oxygen & dressings) are not always available at sites especially over weekends.)

Name of Nurse completing this section