

Patient Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Ordering Physician: \_\_\_\_\_

Sending Facility: \_\_\_\_\_ Facility Number: \_\_\_\_\_

Date of Transfer: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Transfer: \_\_\_\_\_ Transporting Company: \_\_\_\_\_

Scheduled Exam/Procedure: \_\_\_\_\_

Reason: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Assessment: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_

Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ BP: \_\_\_\_\_ BG: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

**PLEASE SEND A RECENT PHYSICIAN H&P WITH PATIENT AT TIME OF TRANSFER.**

Medications given: \_\_\_\_\_

**PLEASE SEND A CURRENT MEDICATION LIST WITH PATIENT AT TIME OF TRANSFER.**

**Ambulatory Status**

- Independent
- WC / Cane / Walker
- Bed Rest
- Other: \_\_\_\_\_

**Neuro**

- A&O x 3
- Confused
- Lethargic
- Unresponsive \*\*

**GI / GU**

- Colostomy / Ileostomy
- Incontinent
- G / Peg Tube / J Tube
- Foley

**\*\*Blood transfusion patients must have "Hamot Blood Transfusion" orderset completed and a signed blood transfusion consent form at time of transfer.**

\*\*ATTN if >6LNC O2, Vent, Intubated, Airborne or TB Isolation - these patients do not meet outpatient criteria and must go to Inpt/ICU.

\*\* If patient unresponsive, contact outpatient charge nurse beeper # 877-0752.

**Communication Barriers**

- None
- Glasses / Blind
- Deaf / Hard of Hearing / Hearing Aids
- Non-English Speaking:

Language: \_\_\_\_\_

Interpreter: \_\_\_\_\_

**Respiratory / Cardiac**

- O2 liters: \_\_\_\_\_ \*\* Via: \_\_\_\_\_
- Trach / Intubated \*\*
- SOB / Cough
- EKG (rhythm): \_\_\_\_\_
- Pacemaker / ICD

**Wound / Skin / IV**

- Drains / Wound Vac  
Location & Type \_\_\_\_\_
- Pressure Ulcer/Sore  
Location & Size \_\_\_\_\_
- IV / Central Line  
Location & Size \_\_\_\_\_

Staff Completing Form: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_

Emergency Contact/Family: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Isolation (✓ all that apply)**

- None
- Contact - MRSA / c. Diff
- MDRO - VRE / c. Diff
- Droplet \*\*
- Airborne (TB) \*\*

**Diet**

- Regular
- Tube Feeding Rate  
Formula & Rate \_\_\_\_\_
- NPO Time: \_\_\_\_\_
- Other: \_\_\_\_\_

**Labs (Value & Date)**

- BUN \_\_\_\_\_
- Creatinine \_\_\_\_\_
- PT / INR \_\_\_\_\_
- Glucose \_\_\_\_\_
- Hgb \_\_\_\_\_
- Hct \_\_\_\_\_
- Plt \_\_\_\_\_

PATIENT LABEL

**Outpatient Service  
Communication Form  
for Persons from  
Residential Living  
Providers**

D-1-418 (04-07-09)



\*MD0620\*

