Facility Details:

REFERRAL OR TRANSFER LETTER FROM AGE RELATED RESIDENTIAL CARE (VERSION 2012)

Please keep a copy of this letter

Resident's Full Name (or fix resident label)	Transfer/discharge date to Acute Care:	
	GP name:	
	GP phone number:	
NHI	Transfer authorised by the residents GP:	Yes No
	If NO who authorised the transfer:	
Date of Birth	Contact phone number:	
	Name of the RN to contact at the facility:	
	Phone Number:	
	Admission date to this facility:	

What are the signs and symptoms that have triggered this transfer / referral

NORMAL Baseline Recordings Date taken:	TPR	BSL	BP	O_2 sat %	Weight KG
LAST recordings taken Taken Date: Taken Time:	TPR	BSL	BP	O_2 sat %	Weight KG
Known history of multi-drug resistant organisms	ESBL MRSA VRE Other				
Flu vaccination status (date) Pneumococcal vaccination (date)	Infection history: TB recent treatment for scabies recent history of norovirus				

Known allergies or drug reactions:

Copy of latest medication prescribing sheet must included in the transfer envelope or attached

Please include the last two days of progress notes if possible.

EPOA/ family Contact Name	Relationship	Phone Day	Phone Night	Other Comments

Sleep

Sleeps well Usually wakeful but settled Usually wakeful and is restless

Sleeps often during the day

Pain

Does not usually complain of pain Sometimes has pain Frequently or always has pain

Has regular medication for pain Needs pain relief at night

How intense is the pain: (Circle) (Nil) 1 – 2 - 3 – 4 – 5 -6 - 7- 8 -9 - 10 (excruciating)

Site/s of pain: What causes the pain:

How do I know this person has pain: What relieves the pain:

Pain management is complex and requires frequent RN assessment

Last pain relief given (What) (Dose) (Time)

Is there anything that the receiving staff need to know about this resident immediately?

Facility Details:

Name NHI

NORMAL STATUS FOR THIS RESIDENT

MENTAL STATE	SKIN STATUS	CONTINENCE	
Alert Slightly Confused Very Confused Forgetful Wanders	Fragile Dry Intact Lesions Bruising Wound/skin tears	BLADDER Continent Continent if toileted regularly Nocturnal incontinence only Incontinent Uses continent products; type and size;	BOWELS Normal Requires regular aperients Type Constipated Incontinent
Memory loss; Mild Moderate Severe	Pressure injury risk HIGH MEDIUM LOW	Indwelling catheter: Date changed	Bowels last open: Normally moves every.....days
COMMUNICATION First language is;	Pressure injuries present; (describe site and stage)		Recent diarrhoea or vomiting?
Speech is clear Speech not clear Unable to speak	Special seating cushion in use Frequency of position changes: Understands and follows instructions YES NO	Special mattress in use	

MOBILITY	HYGIENE (ADLS)	NUTRITION AND HYDRATION	
Walks unaided Walks with walking stick Walks with crutches Walks with walking frame Wheelchair bound Bed/chair resting Weight bearing Non weight bearing Requires supervision Is unsafe if unsupervised High risk for falls Hoist (type)	Independent Needs assistance Dependent PERSONAL AIDS Glasses Hearing Aid Dentures Pacemaker Other	Full Soft Bite Size Puree Thickened fluids Diabetic Low fat Low salt High Protein Vegetarian Other	Feeds self Needs assistance Dependent Usual amount of intake In 24 hours: Usual food intake Large Medium Small Last ate or had fluids at:

Moving/transferring the resident; 1 nurse 2 nurses More than 2 nurses Transferring belt Slippery Sam

Wounds, skin lesions and care

Cultural / Spiritual

Resident goals / concerns

Known Advanced Directives / Advance Care Plan (copy can be placed in the transfer envelope or attached)

Nurse's Signature	Nurse's Name and contact number : please print	Date

If unable to complete all sections of this form before the ambulance arrives send as much as you have completed. Once fully completed this form can be faxed to CMDHB Emergency Care on: FAX: 276 0078
(Please advise EC staff if this is your course of action)