

## ED Transfer Communication Form

Share your feedback!



*This form was developed to promote consistent, concise, and relevant patient information between a nursing home and Emergency Department, when a nursing resident experiences a change in condition that requires evaluation in an acute care setting.*

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|  | <b>A copy of the patient's medication list</b> or printed MAR   |
|  | <b>Any available legal documentation</b> on the patient's CODE STATUS, including any POLST forms, advanced directives, living will, etc.  |
|  | <p><b>1. Why is this individual a resident or patient in your facility?</b><br/> <i>(check all that apply and add additional details/explanation)</i></p> <p> <input type="checkbox"/> Cognitive Delays                      <input type="checkbox"/> Memory Issues                      <input type="checkbox"/> Mental Health Disorder                      <input type="checkbox"/> Physical Limitations<br/> <input type="checkbox"/> Recent Hospitalization(s)                      <input type="checkbox"/> Chronic Respiratory Needs         </p> <p>Additional Details / Explanations:</p>  |
|  | <p><b>2. What chronic medical conditions does the patient have?</b></p> <p> <input type="checkbox"/> Diabetes                      <input type="checkbox"/> Heart Failure                      <input type="checkbox"/> Coronary Artery Disease                      <input type="checkbox"/> A-Fib<br/> <input type="checkbox"/> Hypertension                      <input type="checkbox"/> Cancer (being treated)                      <input type="checkbox"/> COPD                      <input type="checkbox"/> Asthma<br/> <input type="checkbox"/> Stroke                      <input type="checkbox"/> Dementia                      <input type="checkbox"/> Mental Health Issue                      <input type="checkbox"/> Other:         </p> |
|  | <p><b>3. What is the baseline mental status of this patient?</b></p> <p> <input type="checkbox"/> Confused                      <input type="checkbox"/> Developmentally Delayed                      <input type="checkbox"/> Combative / Agitated                      <input type="checkbox"/> Non-Verbal<br/> <input type="checkbox"/> Non-Responsive                      <input type="checkbox"/> Other:         </p>   |
|  | <p><b>4. What is the primary concern regarding the patient today? What prompted a call to 911?</b><br/> <i>(describe patient symptoms and/or behaviors, when they began; if applicable - concerns the referring provider had when you called)</i></p>   |
|  | <p><b>5. Who are the emergency contacts for the patient?</b><br/> <i>(name, relationship, phone number)</i></p>   |
|  | <p><b>6. What is the name of the physician or provider who referred the patient to the ED?</b><br/> <i>(name, phone number)</i></p>   |

\_\_\_\_\_  
 Name / Credentials of Individual Completing Form

\_\_\_\_\_  
 Facility Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Facility Phone