Nursing Home to Acute Hospital (SVHG) Transfer letter

Primary Care Information

Nursing Home: _____

_____

Phone Number: _____

Fax number: _____

GP Name: _____

GP Phone No: _____

Personal Information

Name: _____

DOB: __/__/__

Specified NOK: _____

NOK Phone No: _____

Medical Information

Referral reason: _____

Medicines list attached *(please circle):* Y / N

Medical History attached *(please circle):* Y / N

Specific Palliative Care/End of Life needs attached: *(please circle):* Y / N

DNR order attached *(please circle):* Y / N

Infection Risk: Y / N Antibiotic resistant organism identified e.g. *MRSA* Specify: _____

Healthcare-associated infection e.g. *C. Difficile* infection: Specify: _____

Eradication protocol attached *(please circle):* Y / N

Patient aware: *(please circle):* Y / N

Physical Information

Mobility *(please circle):* Independent Stick Frame Assistance 1 or 2 Wheelchair Immobile

Transfer *(please circle):* Independent Assistance 1 or 2 Standing Hoist Full Hoist

Falls Risk *(please circle):* Low Medium High

Functional level (Barthel): ___/20

If unsure, please describe:

Skin Integrity *(please circle):* Intact Grade 1 Grade 2 Grade 3 Grade 4

Location (if applicable) _____ Waterlow Score: __/47

Nutrition Weight ____ kgs MUST Score: _____

Diet Modification *(please circle):*

Diet: Normal Texture A Texture B Texture C Texture D

Fluids: Normal Grade 1 Grade 2 Grade 3 Grade 4

If unsure, please describe: _____

Continence *(please circle):*

Incontinent of urine: Day Night Day & Night

Incontinent of bowel: Day Night Day & Night

Urinary Catheter: Y / N Next change date: __/__/__

Type: Size:

Cognition: MMSE __/30 AMTS __/10

If unsure, please describe: _____

Communication *(please circle):* Normal Functional verbal communication Limited verbal No verbal

Accompanying patient *(please circle):* Spectacles Hearing Aid Dentures

Any other relevant information included *(please circle):* Y / N (Please attach on a separate sheet)

Signed: Grade: Date: __/__/__