Place patient sticker **within** this box

NHS

Inter/Intra hospital and care home transfer

The transferring ward must ensure that the form accompanies the patient on transfer
NB – for staff receiving a telephone handover, use CHA2938 to document this

S

Transferring Ward/Department/Hospital .....
Receiving Ward/Department/Hospital/Care home .....
Reason for admission.....
Diagnosis .....
On Oxygen? Yes ☐ / No ☐ Device..... %.....
Medically reviewed in the last 24 hrs and fit for transfer Yes ☐ No ☐
Telephone handover provided: Date: ...../...../..... Time: :
Name/Designation of staff member who received handover .....

B

Past Medical History .....
.....
Social History.....
.....

A

Recent NEWS score..... Date: ...../...../..... Time: if applicable, reason for raised NEWs
.....

TEP and Resuscitation Record: Yes ☐ if **YES**, indicate decision
Attempt cardiopulmonary resuscitation ☐
Allow a natural death – do not attempt cardiopulmonary resuscitation ☐
Is Pre-Notified Death Form in place? Yes ☐ No ☐ Not Applicable ☐

Infection Risk (e.g loose stool, C.Diff, MRSA, Covid)..... Date sample sent ...../...../.....
Plan .....

Mobility status (include number of staff, equipment, method if applicable).....
Transfers status (include number of staff, equipment, method if applicable).....

Activities of daily living		Washing	Dressing	Toileting	Eating	Drinking
	Independent with:	☐	☐	☐	☐	☐
	Needs assistance with:	☐	☐	☐	☐	☐

Risk of falls: Yes ☐ No ☐ if **YES**, indicate risk factors below:
History of falls last 12 months ☐ Fallen during this admission ☐
Cognitive impairment (i.e delirium/dementia) ☐ Unwilling to use call bell ☐
Medications that increase risk ☐ Postural hypotension ☐ Urgency/incontinence ☐
Risk of falling from bed ☐ Other: .....

Bedrails assessment outcome: Not required ☐ Bedrails to be used ☐ Bedrails **not** to be used ☐
if **not** to be used, state alternative interventions: .....

Increased observation required? Yes ☐ No ☐ if **YES**, indicate intervention below:
Enhanced care Level 4 (within arm's reach) ☐ Level 3 (within line of sight) ☐
Level 2 (increased care rounding) ☐ Frequency of care rounding: ..... **Other:** Alarm mat ☐

Behavioural concerns? Yes ☐ No ☐ if **YES**, indicate behaviour/s below:
Wandering ☐ Aggressive ☐ Sundowning ☐ Low Mood ☐ Risk of absconding ☐
Other:.....

Place patient sticker **within** this box

A

Is Deprivation of Liberty Safeguard (DoLS) in place? Yes ☐ No ☐ if **YES**, provide date:

'This is me' support tool in place? Yes ☐ No ☐
Other Health passport/s? Yes ☐ No ☐ if **YES**, provide details .....

Communication concerns? Yes ☐ No ☐ if **YES**, indicate below:
Vision impairment ☐ Hearing impairment ☐ Wears glasses ☐ Wears hearing aids ☐
Language Barrier/Requires translator? Yes ☐ No ☐ If yes, provide details:.....
Any other additional communication needs?: .....

Nutritional management concerns? Yes ☐ No ☐ if **YES**, complete details below:
MUST Score: Low ☐ Medium ☐ High ☐
Swallowing difficulties ☐ Fluid restriction ☐ Poor appetite ☐
Special diet details.....
Hydration and food chart? Yes ☐ No ☐
Modified texture diet ☐ IDDSI level .....
Modified fluids ☐ IDDSI level .....
Enteral feeding? Yes ☐ No ☐ if **YES**, provide details .....

Fluid balance monitoring? Yes ☐ No ☐ if **YES**, what is the reason:

Continence concerns? Yes ☐ No ☐ if **YES**, indicate strategy used:
Pads & pants ☐ Urine bottle ☐ Conveen ☐ Stoma ☐ Toileting regime ☐
Catheter ☐ (if catheter in use complete details below)
Date catheter inserted: ...../...../..... Reason: Date trialled without catheter: ...../...../.....
Catheter passport? Yes ☐ No ☐ Date bowels last opened: ...../...../.....

Skin integrity concerns / wound / pressure ulcers? Yes ☐ No ☐
if **YES**, describe what / where:
Datix incident number:

Critical medicines? Yes ☐ No ☐ if **YES**, indicate below:
Insulin ☐ Antibiotics ☐ Anti-coagulant ☐ Parkinson's meds ☐ Cardiac ☐
Other:.....

Controlled drugs? Yes ☐ No ☐ if **YES,** indicate:

Intravascular line? Yes ☐ No ☐ Type: Date of insertion: ...../...../.....

Allergies? Yes ☐ No ☐ if **YES**, describe:

Discharge medications - *applicable to inter transfer only*
To Take Out (TTO') ☐ Medicine Administration Prescription (MAPP) ☐ Medicine Administration Charts ☐

Self administration of medication ☐

End of life care? Yes ☐ No ☐

Syringe driver? Yes ☐ No ☐ Start time:

R

Discharge goals (where appropriate include details to why a community hospital bed is required / what must be achieved before the patient can be discharged from hospital care):

Other relevant information (ie: appointments, tests, Neuro-observations)

D

Next of kin informed? Yes ☐ No ☐ Contact name:

By signing I confirm that the patient is **CLEAN** and **COMFORTABLE** at time of Transfer:

Print Name: **Signature:** **Designation:**

Date: Time: Photocopy of form taken to be filed in patient's notes ☐

To be completed by receiving ward/department/hospital/care home

By signing I confirm that I have reviewed the content of the transfer form *(please ensure form is filed in patient's notes)*

Print Name: **Signature:** **Designation:**

Date: Time: