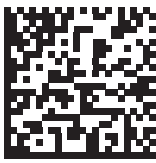


Place patient sticker **within** this box

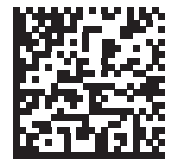
Inter/Intra hospital and care home transfer

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																										
B	Reason for admission.....																										
	Diagnosis																										
A	On Oxygen? Yes <input type="checkbox"/> / No <input type="checkbox"/> Device..... %.....																										
	Medically reviewed in the last 24 hrs and fit for transfer Yes <input type="checkbox"/> No <input type="checkbox"/>																										
	Telephone handover provided: Date:/...../..... Time: :																										
	Name/Designation of staff member who received handover																										
	Past Medical History																										
	Social History																										
	Recent NEWS score Date:/...../..... Time: if applicable, reason for raised NEWS																										
	TEP and Resuscitation Record: Yes <input type="checkbox"/> if YES , indicate decision																										
	Attempt cardiopulmonary resuscitation <input type="checkbox"/>																										
	Allow a natural death – do not attempt cardiopulmonary resuscitation <input type="checkbox"/>																										
	Is Pre-Notified Death Form in place? Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/>																										
	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).....																										
	<table border="1"><thead><tr><th>Activities of daily living</th><th></th><th>Washing</th><th>Dressing</th><th>Toileting</th><th>Eating</th><th>Drinking</th></tr></thead><tbody><tr><td>Independent with:</td><td></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Needs assistance with:</td><td></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></tbody></table>							Activities of daily living		Washing	Dressing	Toileting	Eating	Drinking	Independent with:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs assistance with:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activities of daily living		Washing	Dressing	Toileting	Eating	Drinking																					
Independent with:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																					
Needs assistance with:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																					
	Risk of falls: Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate risk factors below:																										
	History of falls last 12 months <input type="checkbox"/> Fallen during this admission <input type="checkbox"/>																										
	Cognitive impairment (i.e delirium/dementia) <input type="checkbox"/> Unwilling to use call bell <input type="checkbox"/>																										
	Medications that increase risk <input type="checkbox"/> Postural hypotension <input type="checkbox"/> Urgency/incontinence <input type="checkbox"/>																										
	Risk of falling from bed <input type="checkbox"/> Other:																										
	Bedrails assessment outcome: Not required <input type="checkbox"/> Bedrails to be used <input type="checkbox"/> Bedrails not to be used <input type="checkbox"/>																										
	if not to be used, state alternative interventions:																										
	Increased observation required? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate intervention below:																										
	Enhanced care Level 4 (within arm's reach) <input type="checkbox"/> Level 3 (within line of sight) <input type="checkbox"/>																										
	Level 2 (increased care rounding) <input type="checkbox"/> Frequency of care rounding: Other: Alarm mat <input type="checkbox"/>																										
	Behavioural concerns? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate behaviour/s below:																										
	Wandering <input type="checkbox"/> Aggressive <input type="checkbox"/> Sundowning <input type="checkbox"/> Low Mood <input type="checkbox"/> Risk of absconding <input type="checkbox"/>																										
	Other:																										



Place patient sticker **within** this box



A	Is Deprivation of Liberty Safeguard (DoLS) in place? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , provide date:	
	'This is me' support tool in place? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Other Health passport/s? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , provide details	
	Communication concerns? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate below: Vision impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears hearing aids <input type="checkbox"/> Language Barrier/Requires translator? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide details:..... Any other additional communication needs?:	
	Nutritional management concerns? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , complete details below: MUST Score: Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Fluid restriction <input type="checkbox"/> Poor appetite <input type="checkbox"/> Special diet details..... Hydration and food chart? Yes <input type="checkbox"/> No <input type="checkbox"/> Modified texture diet <input type="checkbox"/> IDDSI level Modified fluids <input type="checkbox"/> IDDSI level Enteral feeding? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , provide details	
	Fluid balance monitoring? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , what is the reason:	
	Continence concerns? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate strategy used: Pads & pants <input type="checkbox"/> Urine bottle <input type="checkbox"/> Conven <input type="checkbox"/> Stoma <input type="checkbox"/> Toileting regime <input type="checkbox"/> Catheter <input type="checkbox"/> (if catheter in use complete details below) Date catheter inserted:/...../..... Reason: Date trialled without catheter:/...../..... Catheter passport? Yes <input type="checkbox"/> No <input type="checkbox"/> Date bowels last opened:/...../.....	
	Skin integrity concerns / wound / pressure ulcers? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , describe what / where: Datix incident number:	
	Critical medicines? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate below: Insulin <input type="checkbox"/> Antibiotics <input type="checkbox"/> Anti-coagulant <input type="checkbox"/> Parkinson's meds <input type="checkbox"/> Cardiac <input type="checkbox"/> Other:.....	
	Controlled drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , indicate:	
	Intravascular line? Yes <input type="checkbox"/> No <input type="checkbox"/> Type: Date of insertion:/...../.....	
	Allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> if YES , describe:	
	Discharge medications - <i>applicable to inter transfer only</i> To Take Out (TTO') <input type="checkbox"/> Medicine Administration Prescription (MAPP) <input type="checkbox"/> Medicine Administration Charts <input type="checkbox"/>	
	Self administration of medication <input type="checkbox"/>	
	End of life care? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Syringe driver? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Contact name:	
By signing I confirm that the patient is CLEAN and COMFORTABLE at time of Transfer:		
Print Name:	Signature:	
Date:	Time:	
Photocopy of form taken to be filed in patient's notes <input type="checkbox"/>		
To be completed by receiving ward/department/hospital/care home		
By signing I confirm that I have reviewed the content of the transfer form (<i>please ensure form is filed in patient's notes</i>)		
Print Name:	Signature:	
Date:	Time:	