SNF/ED COMMUNICATION FORM

FACILITY CONTACT INFORMATION

Skilled Nursing Facility Name: Date: _____ Time: _____

Form Completed By (Print name): Goal/Type of Stay at Facility: ☐ SAR ☐ LTC ☐ Palliative ☐ Hospice ☐ Dialysis

Who can the Hospital ED Physician call to discuss this patient (*include Name and Phone Number*):

☐ Physician/Provider Contact: _____ Phone Number: _____

☐ Medical Director: _____ Phone Number: _____

PATIENT INFORMATION

Patient Name: | DOB: | ☐ Male ☐ Female | Preferred Language:

Patient's Emergency Contact (Name & Phone Number): | Health Care Proxy: ☐ Yes ☐ No

Code Status: ☐ Full Code ☐ DNR ☐ DNI MOLST Form Sent w/ Pt: ☐ Yes ☐ No DNR Form Sent w/ Pt: ☐ Yes ☐ No

Reason for Hospital Transfer:

Expected Course of Care for Patient:

Family-Driven Transfer: ☐ Yes ☐ No

Other Pertinent Information (include relevant past medical history):

Belongings Sent w/ Pt: ☐ Hearing Aides ☐ Dentures ☐ Other: _____

VITAL SIGNS AND DIAGNOSTICS AT TRANSFER

HT:	WT:	BP:	TEMP:
PULSE:	PULSE OX:	RESP:	LAST BLOOD SUGAR (if relevant):

Diet: ☐ Regular ☐ Soft ☐ Puree ☐ NPO ☐ G-Tube ☐ Aspiration Precautions ☐ Fluid Restriction: _____

Allergies:

Isolation Precautions: ☐ None ☐ Contact ☐ Droplet ☐ Airborne ☐ MRSA ☐ VRE ☐ C-Diff ☐ Other: _____

Reason for Isolation: _____

BASELINE MENTAL STATUS

☐ Alert ☐ Oriented ☐ Disoriented ☐ Dementia ☐ Lethargic ☐ Comatose ☐ Agitated

☐ Depressed ☐ Calm ☐ Anxious ☐ Combative ☐ Other: _____

BASELINE ADLS

☐ Ambulates independently ☐ Ambulates with assistance ☐ Fall-risk ☐ Wanders ☐ O2 Dependent: _____

☐ Incontinent to Urine ☐ Incontinent to Stool ☐ Poor Speech ☐ Poor Hearing ☐ Other: _____

ATTACHMENTS

The following must be attached: Facesheet MAR Signed DNR MOLST Advance Directives

Additional Attachments: ☐ Treatments ☐ X-rays ☐ EKGs ☐ Surgical Reports ☐ Most Recent Labs

☐ Skin Guide ☐ Immunization Records ☐ Other: _____

SPECIAL CONDITIONS

Check All That Apply: ☐ Skin Wounds ☐ Dialysis ☐ Foley Catheter Date of Foley Insertion: _____

IV Access: ☐ PICC ☐ Port ☐ Other _____ | ☐ Pacemaker Mfr.: _____ ☐ ICD Mfr.: _____

RECENT HOSPITAL ADMISSION

Did the patient have an inpatient hospital stay within the last 30 days? ☐ Yes ☐ No If yes, primary reason: _____

Comments/Pertinent SNF Clinical Capabilities: