

METROPOLITAN WASHINGTON AREA INTER-AGENCY REFERRAL TRANSFER FORM

PATIENT NAME:			MR #:	TRANSFERRING FACILITY:	UNIT:
ADDRESS / APT:			TEL #:	REFERRAL TO:	
CITY:	STATE:	ZIP:	TEL #:	FAX #:	
DOB:	AGE:	<input type="checkbox"/> M <input type="checkbox"/> F MARITAL STATUS:	SSN #:	MEDICARE ID #:	A & B A B
RELATIVE / GUARDIAN:			MEDICAID ID & CODES:		
RELATIONSHIP:			TEL #:	OTHER INSURANCE NAME:	TEL #:
ADDRESS / APT:			INSURANCE #:		
CITY:	STATE:	ZIP:	DATE ADMITTED:	DATE DISCHARGED:	
ALLERGIES:			SKIN INTACT? <input type="checkbox"/> Y <input type="checkbox"/> N IF "N" (NO), SKIN CARE SHEET ATTACHED? <input type="checkbox"/> Y <input type="checkbox"/> N		
PRIMARY DIAGNOSIS:					
SECONDARY DIAGNOSIS:					
VITAL SIGNS:	TEMP:	P:	R:	B / P:	R / L: SIT / LIE / STAND
CHIEF COMPLAINT:					

SERVICES	DESCRIPTION OF THERAPY			WEIGHT BEARING STATUS			
<input type="checkbox"/> PHYSICAL THERAPY				<input type="checkbox"/> NON-WEIGHT BEARING			
<input type="checkbox"/> OCCUPATIONAL THERAPY				<input type="checkbox"/> PARTIAL-WEIGHT BEARING			
<input type="checkbox"/> SPEECH THERAPY				<input type="checkbox"/> FULL-WEIGHT BEARING			
<input type="checkbox"/> RESPIRATORY THERAPY							
<input type="checkbox"/> COMPANION							
<input type="checkbox"/> DIALYSIS	FREQUENCY:	LOCATION:	TEL #:				
SELF-CARE STATUS:	INDEP	ASSIST	UNABLE	DISABILITIES		SENSORY IMPAIRMENT	
A D L S	BED TO CHAIR			TYPE	DESCRIBE	TYPE	EXPLAIN
	WALKING			<input type="checkbox"/> AMPUTATION		<input type="checkbox"/> SPEECH	
	STAIRS			<input type="checkbox"/> PARALYSIS		<input type="checkbox"/> HEARING	
	WHEELCHAIR			<input type="checkbox"/> CONTRACTURES		<input type="checkbox"/> VISION	
	CRUTCHES			<input type="checkbox"/> OTHER		<input type="checkbox"/> SENSATION	
	WALKER					<input type="checkbox"/> OTHER	
	BATHE			COMMUNICAT'NS	SOCIAL	MENTAL STATUS	
	DRESS			<input type="checkbox"/> UNABLE TO WRITE	<input type="checkbox"/> WORKS IN GROUPS	<input type="checkbox"/> ALERT	<input type="checkbox"/> ORIENTED
	FEED			<input type="checkbox"/> UNABLE TO SPEAK	<input type="checkbox"/> LONER	<input type="checkbox"/> FORGETFUL	<input type="checkbox"/> WANDERS
	BRUSHING TEETH			<input type="checkbox"/> UNDERSTANDS SPEECH		<input type="checkbox"/> CONFUSED	<input type="checkbox"/> SUNDOWNER
	SHAVING			<input type="checkbox"/> UNDERSTANDS ENGLISH		<input type="checkbox"/> WITHDRAWN	<input type="checkbox"/> DIFFICULTY SLEEPING
	TOILET			<input type="checkbox"/> IF NO, SPECIFY LANGUAGE		ELIMINATION	
	COMMODE			<input type="checkbox"/> READS		<input type="checkbox"/> OSTOMY	INCONTINENCE
BEDPAN / URINAL			<input type="checkbox"/> OTHER		CATHETER (URINARY)	<input type="checkbox"/> BLADDER <input type="checkbox"/> BOWEL	
RX ADMIN					SIZE:	DATE:	
					DATE LAST BM		

PATIENT NAME: _____

SSN: _____

MEDICATIONS GIVEN DAY OF D/C	DOSE	FREQUENCY	MEDICATIONS GIVEN DAY OF D/C	DOSE	FREQUENCY

PSYCHO - SOCIAL INFORMATION:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> NO PROBLEMS NOTED | <input type="checkbox"/> COOPERATIVE | <input type="checkbox"/> DEPRESSED / WITHDRAWN | <input type="checkbox"/> ANGRY / HOSTILE |
| <input type="checkbox"/> REPORTS MOOD SWINGS | <input type="checkbox"/> SLEEP DISTURBANCE | <input type="checkbox"/> AGITATED | <input type="checkbox"/> ANXIOUS |
| <input type="checkbox"/> FLAT AFFECT | <input type="checkbox"/> LACK OF EVIDENT SUPPORT SYSTEMS | | |
- HYGIENE:** EXCELLENT GOOD FAIR POOR

TRANSPORTATION ISSUES (if any):

EXPLAIN NECESSARY DETAILS OF CLIENT / FAMILY TEACHING:

DIABETES:

WOUND:

MEDICATIONS:

NUTRITION / DIET / C-TUBE:

OSTOMY:

ADL / MOBILITY / TRANSFERS:

OTHER:

ADDITIONAL INFO:

PERSONAL
BELONGINGS
AND
EQUIPMENT

- WITH PATIENT
 TO FAMILY

EYESIGHT: CONTACT LENS EYEGLASSES
DENTURES: FULL UPPER LOWER
ASSISTIVE DEVICE:
HEARING AID: LEFT RIGHT
PROSTHESIS (Type):

- | | | | |
|--|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> CODE STATUS: | | <input type="checkbox"/> SENT WITH PATIENT | _____ YES _____ NO |
| <input type="checkbox"/> ADVANCED DIRECTIVES | _____ YES _____ NO | <input type="checkbox"/> STS | _____ NEGATIVE _____ POSITIVE |
| <input type="checkbox"/> COPY OF MOST RECENT EKG SENT WITH PATIENT | | | |
| <input type="checkbox"/> TB | _____ NEGATIVE _____ POSITIVE | | |

PRINTED NAME:

SIGNATURE

PHONE:

DATE:

