



Massachusetts  
Department of  
Public  
Health

Instructions for Completion of Transfer Referral and Order Form

1. This new *Transfer Referral and Order Form* packet **takes the place** of the 3 page patient care referral form or other transfer forms or systems currently in use at your institution.

2. The packet has the following sections:

- a. **Contact Information & Checklist** (page 1)
- b. **Patient Safety and Order Forms** (pages 2-4)
- c. **Tests, Appointments, Notes, & Certification Form** (page 5)
- d. **Anticoagulation Referral Form and Warfarin Flow Sheet**

(page 6). Note that for many patients, this page will be marked "N/A."

Depending on the type of patient, additional documentation may be required for a safe and effective transfer (e.g., specific instructions related to high risk OB patients, transplant patients, etc.). Determining which additional documents are needed is left to the discretion of the sending and receiving clinical teams.

3. Unlike some previous forms, the new packet does not necessarily have separate pages for each clinician to complete (e.g., page for RN, page for MD, page for SW). While the form is designed to have page 2 as the primary physician page, clinical teams within each institution must determine who will complete each page of the form, ultimately the MD/NP/PA **must** co-sign each page of the order form, indicating that he/she has reviewed all of the information for accuracy and completeness. (Note: during off hours in institutions such as nursing homes, rest homes or home health agencies, when an MD/NP/PA may not be available, an RN may complete the form and send with the patient, pending review by the MD during a verbal report with the next set of providers).

4. ***In a true emergency, e.g., when a patient who has become acutely ill is being sent from home health or a skilled nursing facility to the emergency department (ED), there may only be time to complete the essential information on a patient (the checklist on page 1 and page 2); the rest of the packet can be faxed to the ED after EMS has transported the patient for emergency care***

\*\*This pilot version does not include patient education instructions – those are under development and will be added to subsequent versions.\*\*



**IN CASE OF EMERGENCY PLEASE FILL OUT PAGE 1 & 2 ONLY AND FAX THE REST TO THE EMERGENCY DEPARTMENT AFTER THE TRANSFER HAS TAKEN PLACE**

Patient: Last Name _____ First Name _____ MI _____ DOB: ___/___/___ Address: _____ Phone: _____ Language: English <input type="checkbox"/> Other: <input type="checkbox"/> _____ Gender M <input type="checkbox"/> F <input type="checkbox"/>	Sent to: (Name of Facility/Agency/Other) _____ Address: _____ Phone: _____ ( ) _____ -- _____ Sent from: (Name of Facility/Agency/Other) _____ Date: ___/___/___ Unit: _____
Personal Contact: (Relative, guardian or DPOA/Relationship) _____ name Telephone: ( ) _____ - _____ Is this the health care proxy? <input type="checkbox"/> Y <input type="checkbox"/> N Notified of transfer: <input type="checkbox"/> Y <input type="checkbox"/> N	Has the HCP been invoked? <input type="checkbox"/> Y <input type="checkbox"/> N HCP if different from Contact Person: _____ name Telephone: ( ) _____ - _____ Notified of transfer: <input type="checkbox"/> Y <input type="checkbox"/> N
<b>CURRENT MD/NP/PA:</b> <input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> PA _____ name _____ facility Telephone: ( ) _____ - _____ Pager: ( ) _____ - _____ Fax: ( ) _____ - _____	
Case Manager/Nurse Contact Information: _____ name _____ title Telephone: ( ) _____ - _____ Fax: ( ) _____ - _____	PCP or Clinician Assuming Care: _____ name _____ title Telephone: ( ) _____ - _____ Fax: ( ) _____ - _____

**COPIES/ITEMS SENT WITH PATIENT AT TIME OF TRANSFER:**

CM or RN must initial below. Med list, advance directives, must always accompany patient. Med list may be computer generated but must be attached.

- |  |   |
|--|---|
| ___ Current Medication List                    | ___ Last Progress Note                        |
| ___ Advance Directives                         | ___ Last H+P                                  |
| ___ Out of hospital DNR or MOLST               | ___ Hospital or SNF D/C Summary               |
| ___ Pending Appointments or Laboratory Results | ___ Relevant Lab Results and any Labs pending |

**CONTROLLED SUBSTANCE (NARCOTICS) SENT WITH PATIENT: \_\_\_ YES \_\_\_ NO**

**\_\_\_ PERSONAL BELONGINGS SENT WITH PATIENT:**

- \_\_\_ Eyeglasses \_\_\_ Hearing Aid \_\_\_ Dental Appliance  
 \_\_\_ Other (specify) \_\_\_\_\_

**Signature of ambulance personnel or family member accepting envelope: \_\_\_\_\_**

**Date: \_\_\_/\_\_\_/\_\_\_**

(Please make a copy and keep this for your records)



**Massachusetts Care Transition Form: Referral & Patient Safety Orders**  
**Department of Public Health**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Advance Directive:**  No  Yes **If not addressed why not?** \_\_\_\_\_  
 DNR  DNI  DNH(Do Not Hospitalize)  Full Code \_\_\_\_\_

**Heads Up:** (Clinical Issues Requiring Attention, Special Circumstances or Potential Complications)

**BRIEF SUMMARY** (See D/C Summary for more detail)

Reason for transfer:  
 Summary:

**Goals of Care:**

Hospice:  Yes  No

**Principal Diagnosis at Discharge:** \_\_\_\_\_  
**Additional:** \_\_\_\_\_

**PAIN ASSESSMENT**  
 Pain Score: \_\_\_\_\_ out of \_\_\_\_\_  
 Pain Scoring System used: \_\_\_\_\_  
 Location/s: \_\_\_\_\_  
 Medication/s: \_\_\_\_\_  
 Script/s sent:  Y  N  
 Other treatment modalities: \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**VS:** BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ T \_\_\_\_\_ pO2 \_\_\_\_\_ FS glucose \_\_\_\_\_ Current Weight: \_\_\_\_\_  
 Pulse OX Range: \_\_\_\_\_ Time Taken: \_\_\_\_\_:\_\_\_\_\_:\_\_\_\_ AM/PM

**Mental Status at Discharge:**

Alert, oriented, follows instructions  
 Alert, disoriented, but can follow simple instructions  
 Alert, disoriented, but cannot follow simple instructions  
 Not alert

**Functional Status at Discharge:**

Ambulates independently  
 Ambulates with assistance  
 Ambulates with assistive device  
 Not ambulatory

**IMMUNIZATIONS:**  
 Influenza: Date: \_\_\_/\_\_\_/\_\_\_ Tetanus Booster Date: \_\_\_/\_\_\_/\_\_\_ Tetanus Tet-Diphtheria Date: \_\_\_/\_\_\_/\_\_\_  
 Pneumococcal Date: \_\_\_/\_\_\_/\_\_\_ Other (H1N1 etc.): \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

<p><b>DEVICES/ SPECIAL TREATMENTS:</b></p> <input type="checkbox"/> IV/PICC line/Portacath <input type="checkbox"/> Pacemaker <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Internal Defibrillator <input type="checkbox"/> TPN <input type="checkbox"/> Other: _____ <input type="checkbox"/> If on anticoag, See page 6	<p><b>AT RISK ALERTS:</b></p> <input type="checkbox"/> Pain <input type="checkbox"/> Falls <input type="checkbox"/> Restraints <input type="checkbox"/> Aspiration <input type="checkbox"/> Limited/non-weight bearing <input type="checkbox"/> Elopement	<p><b>ISOLATION/ PRECAUTION:</b></p> <input type="checkbox"/> Seizure <input type="checkbox"/> Pressure Ulcer <input type="checkbox"/> Wanderer <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C-Diff <input type="checkbox"/> Other: _____ Site: _____ Comment: _____
--	--	--

**DISCHARGE PLANNER or CASE MANAGER:**  
 Name: \_\_\_\_\_ Sig: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_

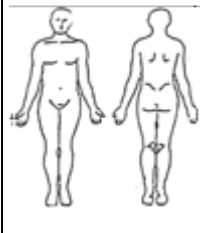
**MD/NP/PA:**  
 Name: \_\_\_\_\_ Sig: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**TREATMENT ORDERS AND FREQUENCY**  
*(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN, fluid restriction, fingersticks, wt checks and freq., attach detail as needed)*

**SKIN / WOUND CARE ORDERS**  
 Pressure ulcers:  
*(stage, location, appearance, treatments)*



Other Wounds :  Yes  No  
 if yes, describe:

Wound care sheet attached:  Yes  No

**CONTINENCE:**

	Bowel	Bladder
Continent	<input type="checkbox"/>	<input type="checkbox"/>
Occasionally Incontinent	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent	<input type="checkbox"/>	<input type="checkbox"/>

Last bowel movement: Catheter last changed:  
 Date: \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Folev Tvpe: Balloon Size: \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING:**  
*(mark I=independent; D=dependent; A=needs assistance)*

_____ Bathing	_____ Toileting/Transfers
_____ Dressing	_____ Ambulation
_____ Eating	

Mobility  
 \_\_\_\_\_ Can ambulate \_\_\_\_\_ (distance) with \_\_\_\_\_  
 (Assistive Device or Independent)

Upper extremities  Normal  Impaired: \_\_\_\_\_  
 Lower extremities  Normal  Impaired: \_\_\_\_\_

**PHYSICAL/OCCUPATIONAL/SPEECH THERAPY**  
 Evaluations:  
 PT:  Yes  No OT:  Yes  No ST:  Yes  No  
 Interventions/Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Detail Attached**  Yes  No

**WEIGHT BEARING STATUS**

Non-weight  Partial weight  Full weight  
 \_\_\_L \_\_\_R \_\_\_L \_\_\_R \_\_\_L \_\_\_R

Amputee  
 Prosthesis use: \_\_\_\_\_  
 Equipment needed at time of transfer: \_\_\_\_\_  
 \_\_\_\_\_

**RESTRICTED ACTIVITIES RESUME DATE/ORDERS**

Bath  \_\_\_\_\_  
 Shower  \_\_\_\_\_  
 Lifting  \_\_\_\_\_  
 Walking  \_\_\_\_\_  
 Climbing Stairs  \_\_\_\_\_

Sexual Activity  \_\_\_\_\_  
 Doing Housework  \_\_\_\_\_  
 Driving  \_\_\_\_\_  
 Going to Work  \_\_\_\_\_  
 Sports  \_\_\_\_\_

**DISCHARGE PLANNER or CASE MANAGER:**

Name: \_\_\_\_\_ Sig: \_\_\_\_\_  
Telephone:( ) \_\_\_\_\_ - \_\_\_\_\_

**MD/NP/PA:**

Name: \_\_\_\_\_ Sig: \_\_\_\_\_  
Telephone:( ) \_\_\_\_\_ - \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b>INSURANCE INFORMATION</b>          Company: _____          Patient Insurance Number: _____          Provider Phone: ( ) _____ - _____  <b>Medicare:</b>          Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> N/A #: _____  <b>Medicaid</b>  <input type="checkbox"/> N/A #: _____</p>	<p><b>DIET ORDERS</b>          Needs assistance with feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No          Trouble swallowing: <input type="checkbox"/> Yes <input type="checkbox"/> No          Special diet or consistency: <i>(thicken liquids, crush meds, etc)</i>          _____          Tube feeding: <input type="checkbox"/> Y <input type="checkbox"/> N Pump _____ Bolus _____          If yes, type of formula: _____ ml/hr _____          water flush _____ ml/hr _____          Additional Diet Orders: (diabetic, low sodium etc)          _____          _____          _____</p>		
<p style="text-align: center;"><b>Communication</b></p> <p>Primary Language: _____          Able to: <input type="checkbox"/> Understand <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write</p> <p>Secondary Language: _____          Able to: <input type="checkbox"/> Understand <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write</p> <p>Aphasia: <input type="checkbox"/> Expressive <input type="checkbox"/> Receptive          Sign language use: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>BEHAVIORAL, SOCIAL, or FAMILY ISSUES &amp; INTERVENTIONS</b></p>		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;"> <p><b>Auditory:</b>  <input type="checkbox"/> Hears Adequately  <input type="checkbox"/> Minimal Difficulty  <input type="checkbox"/> Intermittently Impaired  <input type="checkbox"/> Highly Impaired</p> </td> <td style="width: 30%; padding: 5px;"> <input type="checkbox"/> Uses Auditory Aid                  Type: _____</td> </tr> </table>		<p><b>Auditory:</b>  <input type="checkbox"/> Hears Adequately  <input type="checkbox"/> Minimal Difficulty  <input type="checkbox"/> Intermittently Impaired  <input type="checkbox"/> Highly Impaired</p>	<input type="checkbox"/> Uses Auditory Aid Type: _____
<p><b>Auditory:</b>  <input type="checkbox"/> Hears Adequately  <input type="checkbox"/> Minimal Difficulty  <input type="checkbox"/> Intermittently Impaired  <input type="checkbox"/> Highly Impaired</p>		<input type="checkbox"/> Uses Auditory Aid Type: _____	
<p><b>Vision:</b>  <input type="checkbox"/> Sees Adequately  <input type="checkbox"/> Impaired – sees large print but not regular print.  <input type="checkbox"/> Moderately impaired – limited vision cannot see headlines.  <input type="checkbox"/> Severely impaired – no vision or only sees light, color shapes</p>			
<p><input type="checkbox"/> Uses Visual Aid                  Type: _____</p>			
<p><b>RESPIRATORY CARE</b>  <input type="checkbox"/> Nebulizers  <input type="checkbox"/> Tracheostomy  <input type="checkbox"/> O2 _____ liters via _____  <input type="checkbox"/> Other: _____                  _____</p>			
<p><b>MEDICAL SUPPLY (DME) NEEDS:</b>                  Were supplies ordered? <input type="checkbox"/> Y <input type="checkbox"/> N                  If yes, were they sent? <input type="checkbox"/> Y <input type="checkbox"/> N  <b>FOR MEDICATIONS AT TIME OF DISCHARGE                  PLEASE SEE ATTACHED LIST</b></p>			
<p>Discharge Teaching Completed: <input type="checkbox"/> Y <input type="checkbox"/> N Sig: _____ Teach Back <input type="checkbox"/> Y <input type="checkbox"/> N</p>			
<p>I have participated in and understand the development of this discharge plan. I have received a copy of the plan.                  Patient is not able to understand the information and the representative is not available to sign this form <input type="checkbox"/> Y <input type="checkbox"/> N                  Discharge Nurse's signature _____</p>			

**DISCHARGE PLANNER or CASE MANAGER:**

Name: \_\_\_\_\_ Sig: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**MD/NP/PA:**

Name: \_\_\_\_\_ Sig: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_



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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Tests not due/available until after transfer		Follow – up Appointment Information	
Name of Test:	Date Available: ___/___/___ Due by: ___/___/___	Appointment With:	Date: ___/___/___ Time: _____
Reason for Test:	Contact: _____ Phone: ( ) ___ - _____	Appointment For:	Phone: ( ) ___ - _____
		Appointment needed by ___/___/___	Address: _____ _____
Name of Test:	Date Available: ___/___/___ Due by: ___/___/___	Appointment With:	Date: ___/___/___ Time: _____
Reason for Test:	Contact: _____ Phone: ( ) ___ - _____	Appointment For:	Phone: ( ) ___ - _____
		Appointment needed by ___/___/___	Address: _____ _____
Name of Test:	Date Available: ___/___/___ Due by: ___/___/___	Appointment With:	Date: ___/___/___ Time: _____
Reason for Test:	Contact: _____ Phone: ( ) ___ - _____	Appointment For:	Phone: ( ) ___ - _____
		Appointment needed by ___/___/___	Address: _____ _____

Additional Test Information Attached:  Y  N

Additional Follow-up Information Attached:  Y  N

Additional Notes:

Discipline: \_\_\_\_\_ Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: ( ) \_\_\_ - \_\_\_\_\_

Additional Notes:

Discipline: \_\_\_\_\_ Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: ( ) \_\_\_ - \_\_\_\_\_

Certification: (when applicable) Services above needed to treat condition for which patient was hospitalized  Y  N. I certify that the above named patient is: (check one)  Under my care (or has been referred to another physician having professional knowledge of patient's condition); is home bound except when receiving out-patient services; requires skilled nursing care on an intermittent basis or physical or speech therapy as specified in the orders.  Requires skilled nursing care on a continuing basis for any of the conditions for which he/she received care during this hospitalization.

Form Completed By: \_\_\_\_\_ *name* \_\_\_\_\_ *title*  
\_\_\_\_\_ *signature* \_\_\_\_\_ *phone*

Report Called In By: \_\_\_\_\_ *name* \_\_\_\_\_ *title*  
Report Called To: \_\_\_\_\_ *name* \_\_\_\_\_ *title*

MD/NP/PA: \_\_\_\_\_ *name* \_\_\_\_\_ *title*  
\_\_\_\_\_ *signature* \_\_\_\_\_ *phone*

