LTC Transfer/Discharge Summary

Transferred from:	**Date of Transfer:**
	Contact Number:
Care Recipient Name:	**Date of Birth (dd/mm/yy):**
Reason for Transfer:	

Medical Diagnosis/Health Conditions: list primary diagnosis first/Current problems	Date of onset

Vital signs & time taken	BP:	Pulse:	Temp:	Resp Rate:	Wt:	Blood Sugar:	Pain rating:

Allergies :	☐ Medications:	☐ Food:			
Diet:	■ Regular	☐ Soft	☐ Puree	☐ Special:	
Dental Status:	☐ Own teeth	☐ Upper dentures (with patient-Y/N)	☐ Lower dentures (with patient-Y/N)	☐ Bridge/partial	☐ No teeth
Skin integrity:	☐ Intact	☐ Stage 1	☐ Stage II	☐ Stage III	☐ Stage IV
Cognitive Status	■ Oriented to time, persons and/or place? If not, specify:_____				
	GCS score & date:	Mini Mental Score & date:			
Advanced Care directives:	☐ No	☐ Yes and indicate:	☐ Full Code	☐ DNR	☐ Directives attached

ADLs	**Independent**	**Supervision/ verbal prompts or cueing**	**Physical assistance**			**Total dependence**
			I person	2 person	1 person + lift	
Mobility	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Assistive Devices:	Type and use: Sent with patient? Y/N					
Specific Care preferences/ needs:						

Prescription Medication- (indicate if sent with patient by a Y or N)	**Dosage**	**Route**	**Frequency**	**Purpose**	**Date & time of last dose given**
aspirin and dkalfjdkla					

Responsible Person: ☐NOK ☐ Power of Attorney ☐ Healthcare proxy ☐ OTHER:_____ **Notified?** ☐ Yes ☐ No	**Name:** **Contact Numbers:**
Insurance Number:	**Provider**: ☐HIP ☐ FC ☐WV ☐GEHI ☐ BF&M ☐ARGUS ☐COLONIAL ☐ NONE ☐ OTHER :

Nurse Signature: _____ **Date:_____**

USE BACK PAGE IF ADDITIONAL SPACE IS REQUIRED

If additional space is required:

Prescription Medications (continued) (indicate if sent with patient by a Y or N)	Dosage	Route	Frequency	Purpose	Date & time of last dose given