ED Communication Form

Sent To: (Name of Hospital)_____

Sent From_____

Address: _____ Phone# _____

Contact Person: (Relative or DPOA / Relationship)

Name _____

Is this the health care proxy? [ ] Yes [ ] No

Phone: (____)_____

Notified of Transfer: [ ] Yes [ ] No

Resident Name: (Last Name, First Name, MI)

_____

DOB:_____

Language: [ ] English [ ] Other: _____

Communication Needs: _____

Resident is: [ ] SNF/rehab [ ] Long-term
[ ] Board and Care [ ] Assisted Living

Code Status: [ ] DNR [ ] DNI [ ] Full Code
[ ] Advance Directives

MD/NP/PA in Nursing Home:

_____ NP/PA Name

Reason For Transfer (Use SBAR format) (attach diagnosis list, medication lists and physician orders.)

Interventions Tried: _____

STAT meds given (time & dose or orders completed prior to transfer, if any:_____

_____

VS: BP_____ P_____ R_____ T_____ 02 sats_____ Blood sugar_____ Time taken_____

Last BM _____

ALLERGIES & REACTIONS: _____

Baseline Mental Status:
[ ] oriented to time/place/person
[ ] minor forgetfulness
[ ] total disorientation

Baseline Functional Status:
[ ] Ambulates independently
[ ] Ambulates with assistance
[ ] Ambulates with assistive device
[ ] Not ambulatory

Pain:
[ ] Current Pain Level: _____
Chronic Pain (Location): _____

Devices/Special Treatment:
[ ] IV access [ ] TPN
[ ] Pacemaker [ ] Tube Feeding
[ ] Radiation [ ] Dialysis
[ ] Chemo [ ] Hospice
[ ] Catheter/ Ostomy
[ ] Internal Defibrillator
[ ] Other:_____

At Risk Alerts:
[ ] None
[ ] Falls
[ ] Pressure Ulcer
[ ] Aspiration
[ ] Seizure
[ ] Harm to:
[ ] Self
[ ] Others
[ ] Other: _____

Isolation / Precautions:
[ ] MRSA
[ ] VRE
[ ] C-Diff
[ ] Other: _____
Site:_____
Comment: _____
_____

Skin/Wound Care: Pressure Ulcers: (stage, location, appearance, treatments)_____

Diet Order: _____ Trouble Swallowing: [ ] Yes [ ] No Weight: _____

Valuables sent with patient: [ ] Dentures [ ] Hearing Aids [ ] Glasses [ ] Jewelry [ ] Other: _____ [ ] None

_____ _____ _____

Form Completed by: (Printed Name) Signature Unit Phone # Unit Fax #

[ ] Report called to ER Staff :_____
(Name)

Rice Memorial Hospital
ED Communication Form
3/11
9110-0164-29

Mainkeeper: CM