



AKRON REGIONAL HOSPITAL ASSOCIATION

- Affinity Doctors
Affinity Massillon
Akron City Hospital
Akron Children's Hospital
Akron General Medical Center
Barberton Citizens Hospital
Cuyahoga Falls General
Edwin Shaw Rehab
Lodi Community Hospital
Medina General Hospital

- Mercy Medical Center
Regency Hospital - Barberton
Regency Hospital - Ravenna
Robinson Memorial Hospital
Saint Thomas Hospital
Select Specialty - Mercy
Select Specialty - AGMC
Select Specialty - SHS
WRH Health System



POST-ACUTE TRANSFER FORM - PHYSICIAN ORDERS

MEDICAL INFORMATION

Patient's Name
Last First
Primary Diagnosis
Secondary Diagnosis

SUMMARY OF PRESENT ILLNESS/SIGNIFICANT TESTS, TREATMENTS, AND PROCEDURES - INCLUDE SURGERIES AND DATES:

Prognosis GOOD FAIR POOR

Patient Aware YES NO Responsible Party Aware YES NO

REHABILITATION POTENTIAL (REQUIRED FOR ADMISSION) GOOD FAIR POOR

HISTORY AND PHYSICAL (MUST BE WITHIN 5 DAYS OF DISCHARGE)

YES NO (If No, Please Update)

DIET AND NUTRITIONAL NEEDS

Diet Hyperalimentation
Tube Feedings Supplements

ALLERGIES (LIST):

Table with 2 columns: DISCHARGE MEDICATIONS, DOSE/FREQUENCY/ROUTE

SPECIAL CARE ORDERS

ENEMAS PRN
O2 LITER FLOW:
IV CARE/PICC Date:
Length: Site: Verified by X-ray YES NO
WOUND CARE/DRESSING CHANGES
SUCTION
RESPIRATORY CARE
VENTILATOR/SETTINGS
TV PEEP PCO2 SaO2 SIMV
Additional Orders - includes Tubes, Foleys, IVs
LAB WORK
SAFETY
RESTRAINTS SIDERAILS
SITTER ISOLATION
WANDERS HIGH RISK FOR FALLS
THERAPIES
PT OT ST RT
ACTIVITY/WEIGHT BEARING (WB)
UP AD LIB UP WITH ASSIST
BED REST HOB UP 30 DEGREES
WB AS TOLERATED NON-WB
TOE TOUCH - WB PARTIAL - WB
ASSISTIVE DEVICES
Cane Walker Wheelchair Crutches
Follow up Appointments:

PHYSICIAN INFORMATION

To the best of my knowledge, all information provided is true and accurate
The patient's stay is for convalescence and is expected to be less than 30 days in duration: YES NO

I certify that in-patient care is required at a level of:
LT ACUTE CARE ACUTE REHAB SNF ICF
ASSISTED LIVING HOME CARE HOSPICE CARE
and approve of the plan of care and discharge path.

Physician Signature Date

Print Physician Name

Physician will follow: YES NO

Discharge Date from Hospital

Attending Physician Name

Phone

Pager

See Attached for Additional Orders

DEMOGRAPHICS ON PATIENT

PATIENT INFORMATION

TRANSFERRED TO FACILITY/AGENCY _____

PATIENT'S NAME _____ TELEPHONE _____
 LAST: _____ FIRST: _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

AGE _____ BIRTHDATE _____ SEX M F MARITAL STATUS M S D W

SOCIAL SECURITY # _____ MEDICARE # _____ MEDICAID # _____

OTHER INSURANCE _____ INS # _____ AUTH # _____

IN PATIENT _____ FROM _____ TO _____

HOSPITAL ADMISSION DATES _____

PREVIOUS LIVING ARRANGEMENTS
 Lives Alone Hospice
 Family Home/ Home Care
 Home with Care Giver Passport

AGENCY _____ # _____

PRIMARY CONTACT _____
 DPOA/HC
 DPOA
 Legal Guardian
 RELATIONSHIP TO PATIENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK _____ CELL PHONE _____

SECONDARY CONTACT/NEXT OF KIIN
 NAME _____ PHONE _____
 WHO WAS NOTIFIED OF TRANFER ? _____

TREATMENT RECEIVED WITHIN LAST 14 DAYS **DATE LAST RECEIVED**

Chemotherapy YES

Dialysis YES

IV Medications YES

Oxygen therapy YES

Transfusions YES

Radiation YES

Ventilator YES

Tracheotomy Care YES

Suctioning YES

Pneumonia Vaccine YES

Flu Vaccine YES

Mantoux YES

Vital Signs Range: _____

Last Blood Sugar Result: _____
 Date: _____

Last Pulse Ox (Sa02) Result: _____
 Date: _____

PAIN ASSESSMENT

None Acute Chronic Intermittent Sharp Dull

Other (explain) _____

LOCATION: _____

INTENSITY (1 - 10) _____

ISOLATION **SITE**

MRSA VRE CDIFF ESBL

Site: _____

Other Instructions: _____

PERSONAL POSSESSIONS SENT WITH PATIENT ON DAY OF TRANSFER

Glasses Purse/ Wallet
 Dentures/ Partials Medications
 Hearing Aid Walker/ Cane
 Other _____

Signature of Person Completing Form: _____ Date: _____

SW/ Case Manager Signature: _____ Date: _____

Unit Phone Number: _____

Activities of Daily Living

Activity	Independent	Supervision	Assist/ # Persons	Unable to Do
Turns Self				
Sits				
Bed to Wheelchair				
Transfers				
Ambulation				
Bathing				
Feeding				
Dressing				
Dental Care				
Bedpan				
Bathroom				
Bedside Commode				

HEIGHT _____ WEIGHT _____ DATE _____

CONTINENT BLADDER YES NO

CATHETER SIZE _____ TYPE _____

SUPRAPUBIC SIZE _____ TYPE _____

DATE INSERTED/ CHANGED _____

CONTINENT BOWEL YES NO LAST BM _____

OSTOMY - TYPE _____ DATE CHANGED _____

APPLIANCE _____

APPETITE/ NUTRITIONAL	DISABILITIES
<input type="checkbox"/> GOOD	<input type="checkbox"/> AMPUTATION
<input type="checkbox"/> FAIR	<input type="checkbox"/> PROSTHESIS
<input type="checkbox"/> POOR	<input type="checkbox"/> PARALYSIS
<input type="checkbox"/> HYPERALIMENTATION	<input type="checkbox"/> PARESIS
<input type="checkbox"/> FEEDING TUBE	<input type="checkbox"/> CONTRACTIONS

MENTAL STATUS	BEHAVIOR
<input type="checkbox"/> ALERT	<input type="checkbox"/> COOPERATIVE
<input type="checkbox"/> ORIENTED	<input type="checkbox"/> BELLIGERENT
<input type="checkbox"/> DISORIENTED	<input type="checkbox"/> COMBATIVE
<input type="checkbox"/> FORGETFUL	<input type="checkbox"/> NOISY
<input type="checkbox"/> UNRESPONSIVE	<input type="checkbox"/> ABUSIVE
<input type="checkbox"/> DEPRESSED	<input type="checkbox"/> PASSIVE

SENSORY IMPAIRMENTS

VISION ADEQUATE POOR BLIND

HEARING ADEQUATE POOR DEAF

HEARING AID L R

SPEECH CLEAR DIFFICULT APHASIA

SPEAKS ENGLISH

INTERPRETER REQUIRED

SKIN CARE

SKIN INTACT? Y N

DESCRIBE DECUBITUS/ WOUND - SIZE [CMs], SITE, DRAINAGE

DNR: TRANSFERRING FACILITY [ATTACH COPY]

YES NO

DNR STATUS CC CCAREST OTHER DRN

ADVANCE DIRECTIVES [ATTACH COPY]

LIVING WILL YES NO

DURABLE POWER OF ATTORNEY/HC YES NO

SMOKING CESSATION ADDRESSED YES NO

**AKRON REGIONAL HOSPITAL ASSOCIATION****POST ACUTE TRANSFER FORM****COPY AND SEND TO THE NURSING FACILITY IN THE ORDER LISTED**

Chart Form	Content Needed for Admission	Check Off
Post Acute Skilled Transfer Form	Make sure the secondary payer source area is completed	
MARs	Include the most recent MAR and MARs that have the last dose of an IV med, injections or any chemo (IV or PO). Documentation of blood transfusions	
PT, OT, Speech & Respiratory Therapy	Include the evaluation and notes for last week of stay	
Nutrition Evaluation Form		
Medications	If not individually listed on form, attach computerized listing	
DNR Order Sheet	Either the state form or the hospital form if applicable	
Advanced Directives	Copies of Living Will and/or Durable Power of Attorney for Health Care if on chart	
Physician's Progress Notes	Notes from last 3-4 days	
Nurse's notes/Social Work Notes	Notes from last 2 days; include discharge planning notes; notes including detail on PICC line insertion	
Consultations	A copy of each consult	
Laboratory Results	Most recent labs, including U/A, C&S, CBC, electrolytes, labs used to track dosing of meds (ex; Theophylline/Dilantin level, INRs), MANTOUX	
CXR, EKG	Include most recent	
Cookie Swallow, MRIs, CT Scans	If done, most recent	
H&P and Nursing Assessment with home med sheet	If H&P is dated prior to 5 days before discharge, physician must review, sign, and date	
PASARR ID	Completed Form & results	