Abc **Transfer of Care Form**

**To be completed for all discharges/ transfers to other Hospitals, Nursing and Residential Homes, and for patients receiving a care package in the community**

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| **PERSONAL INFORMATION** | |
| **Patient Label**  **Telephone:** | **Admission Date:**  **Discharge Date:**  **Discharge Consultant:**  **Discharge Ward:**  **Religion:** |
| **Discharge Address if different from home address**  **Telephone:** | **Nearest Relative/ Friend:**  **Address:**  **Telephone:**  **Relationship:**  **Informed of discharge: Yes/ No** |
| **GP Name:**  **Practice Address:**  **Telephone:**  **Discharge Summary faxed:**  **Date: Time:** | **Additional Information from admission:**  **(Adverse reactions, allergies, infection control issues):** |
| **ADMISSION INFORMATION** | |
| **Admitting Diagnosis:**  **PMH on admission:**  **Discharge Diagnosis:** | |
| **Additional problems requiring Specialist referral:** | |
| **Social Circumstances on admission:**  **Care Package on admission:**  **Care Package on discharge:**  **Identified Therapy needs on discharge:** | |
| **SUMMARY OF CARE PROVIDED** | |
| **Pain** | |
| **Pain/ discomfort: Yes / No**  **Location:** | **How managed:** |
| **Mobility and maintaining a safe environment (circle and add detail if required)** | |
| **Falls Risk: Low / Medium / High / Very High** | **Further detail if required:** |
| **‘Walks with intent’: Yes / No** |  |
| **Bed Rails: Yes / No** |  |
| **Independent / AO1 / AO2** |  |
| **Wheelchair / Rotastand / Stick / Zimmer**  **Hoist / Other** |  |
| **Any falls in hospital:** |  |
| **Elimination** | |
| **Bladder Continence: Yes / No** |  |
| **Bowel Continence: Yes / No** |  |
| **Requires Pads: Yes / No** |  |
| **Catheter: Yes / No** | **If Yes:**  **Date of last insertion:**  **Size:**  **Type:** |
| **Other (sheath/ stoma):** |  |
| **Nutritional Needs** | |
| **Nutritional Risk Assessment: Low / Medium / High** | |
| **Dysphagia: Yes / No** | |
| **Appetite: Good / Average / Poor** | |
| **Fluid Intake: Good / Average / Poor** | |
| **Able to feed self: Yes / No** | |
| **Needs Support at meals: Yes / No** | |
| **Diet: Normal / Soft / Easychew / Puree / NG tube / PEG** | |
| **Fluid Consistency:** | |
| **Feeding or swallowing strategies: Yes / No Detail:** | |
| **Teeth: Own / Dentures - Top / Bottom / Both** | |
| **Pressure Ulcer Risk** | |
| **Risk Assessment: Not at Risk / At Risk / Moderate Risk / High Risk / Very High Risk** | |
| **Skin damage on discharge: Yes / No If yes complete the Body Map below** | |
| **Pressure relieving equipment in hospital:**  **Needs on discharge:** | |
| **Repositioning frequency:** | |
| **Body Map: Identify all pressure ulcers, bruising, skin damage/ wounds on discharge** | |

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| **Skin damage/ wound Site** | **Grade if PU** | **Bruise/ Abrasion** | **Other Wound** |
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| **Wound Care** | | | |
| **Wound Care Plan:** | | | |
| **Referred to Community/ Practice Nurse: Yes / No**  **Where:** | | | |
| **Date of first visit:** | | | |
| **3 Days of dressing supplied:**  **Detail:** | | | |
| **Sensory / Communication** | | | |
| **Communication Difficulties: Yes / No**  **Detail:** | | | |
| **Sight: Normal / Glasses / Deteriorating / Partially sighted / Blind** | | | |
| **Hearing: Normal / Hearing Aids: If Yes- R /L / Both / Deteriorating / Deaf** | | | |
| **Mental Health and Mental Capacity Concerns** | | | |
| **Is there a Mental Health diagnosis: Depression / Psychosis / Bi- Polar / Eating Disorder**  **Drug Dependency / Alcohol Dependency** | | | |
| **Is there a Dementia diagnosis / Cognitive Disorder: Yes / No** | | | |
| **Has there been capacity issues: Yes / No** | | | |
| **Has the patient required a capacity assessment: Yes / No**  **Decision Outcome:** | | | |
| **Sleep and Rest** | | | |
| **Sleep Pattern:**  **Requires medication: Yes / No Detail:** | | | |
| **Physiological Observations on discharge** | | | |
| **Pulse: BP: Temp: RR: SAO2:** | | | |
| **Requires O2: Yes / No Detail:** | | | |
| **Additional Information (to include Therapy needs following discharge)** | | | |
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| **Completion of the Form** | | | |
| **Printed Name: Signature: Band:** | | | |
| **Date completed: Ward Contact Number: 01722 336262 ext:** | | | |

**Keep a Copy of the completed form in the Patient Records**