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**