**UNPLANNED TRANSFERS SURVEY FORM**

**Unplanned transfer form to be completed on each transfer patient and can be submitted per your discretion but by the 10th of the following month.**

**Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Transfer Date (month-day-year):** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

**Transfer Time of Day**

**\_\_** Morning (7 a.m. to noon)

\_\_ Afternoon (noon to 7 p.m.)

\_\_ Evening (7 p.m. to midnight)

\_\_ Night (midnight to 7 a.m.)

PLEASE SELECT YES TO ONLY ONE OF THE BELOW. IF PATIENT IS TRANSFERRED TO THE ED, THEN ADMITTED TO THE HOSPITAL, DO NOT COUNT THIS AS AN ED TRANSFER.

**Transfer to ED**: \_\_ Yes \_\_ No

**OR**

**Hospital admission**: \_\_ Yes \_\_ No

**Most Recent Nursing Home** **Admission** **Date** **(month-day-year):** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

*This is the latest date of the most recent admission to the nursing home or the most recent return after a hospitalization.*

**Primary Contributing Reasons for Transfers:** [Please select all that apply.]

**\_\_** Emergent need

**\_\_** Practitioner unable to provide face-to-face assessment

\_\_ Practitioner insisted

\_\_ Supplies/Resources

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Equipment not available

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Lack of diagnostic services

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Resident preference

\_\_ Family preference

\_\_ Nurse insisted

\_\_ Other

* Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Signs and Symptoms leading to Transfer**:

Select the answer that best represents the underlying cause; for example, if the person fell and had lacerations, select falls. Use the space for text to provide additional information when indicated, such as that lacerations resulting from the fall were the reason for the transfer.

\_\_ Abnormal lab

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Abnormal vital signs

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Acute confusion/altered mental status

\_\_ Behavioral symptoms

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Bleeding, other than GI

\_\_ Blood sugar (high/low)

\_\_ Chest pain

\_\_ Constipation

\_\_ Diarrhea

\_\_ Edema (new or worsening)

\_\_ ECG abnormality

\_\_ Fall(s)

* Please describe injuries/reason for admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Fever

\_\_ Functional decline

\_\_ GI bleed

\_\_ Loss of consciousness/unresponsive

\_\_ Nausea/vomiting

\_\_ Pain

* Please specify site of pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Shortness of breath

\_\_ Skin wound or ulcer

\_\_ Urinary incontinence

\_\_ Weight loss

\_\_ Other

* Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Diagnosis**:

*This is the primary diagnosis from the hospital admission or emergency department assessment. This should be obtained from the hospital or emergency department.*

\_\_ No new diagnosis or treatment on return to facility

\_\_ Injury/accident related

\_\_ Cardiovascular related

\_\_ Respiratory related

\_\_ Neurological related

\_\_ Gastrointestinal related

\_\_ Renal/urinary related

\_\_ Hematological/electrolyte related

\_\_ Behavioral/mental health related

\_\_ Pain related

\_\_ Infection related (not respiratory or urinary)

\_\_ Medication related

Additional Comments

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