TRANSFER SUMMARY FOR ADULT RESIDENTIAL CARE HOMES

Resident Name	DOB:	Age:	Sex: M ☐ F ☐	SS#

Transfer Date: _____ **Transferred To:** _____

Reason For Transfer: _____

☐ Emergency Transfer ☐ Non-Emergency Transfer ☐ Thirty Day Written Notification Given / Date: _____

Notification:

☐ MD/Name: _____ Date/Time Notified: _____ ☐ am ☐ pm

☐ CM/Name: _____ Date/Time Notified: _____ ☐ am ☐ pm

☐ Family Notified: _____ Date/Time Notified: _____ ☐ am ☐ pm

Diagnosis: _____

☐ Physician Orders and recommendation

(Attached copies of the most current physical examination; Tuberculosis Clearance, and Physician's Orders, to include diet, medications and level of care).

☐ Advance Directive ☐ Copy Attached

☐ Resident's Records, belongings, valuables given to receiving facility

Language(s) Spoken: ☐ English ☐ Japanese ☐ Tagalog ☐ Ilocano

Other: _____ ☐ No Speech / Impaired Communication

Mobility: ☐ Fully Ambulatory ☐ Cane ☐ Quad Cane ☐ Walker ☐ Wheelchair

☐ Other Assistive Devices / Prosthesis:

Transfers: ☐ Independent ☐ Pivot/One-Man ☐ Two Person ☐ Stand-by Assist

Other: ☐ Fall Precautions ☐ Wheelchair Safety ☐ Range of Motion (Specify): _____

Restraints: (Specify) _____

Activities:

☐ Supervised Day Pass ☐ Unsupervised Day Passes (Physician Order Obtained)

☐ Day Program ☐ Club House ☐ Other: _____

☐ Resident Preferred Activities: _____

☐ Alcohol / Drug Social Use: _____

☐ Smoking ☐ Yes ☐ No Packs/day: _____

Religious / Cultural Concerns/Requests: _____

Receives help from: ☐ Children ☐ Legal Guardian ☐ Parents ☐ Case Manager ☐ Other: _____

ADL's	Bathing:	Dressing:	Grooming:	Toileting:
	☐ Self/Shower ☐ Assisted ☐ Complete	☐ Self ☐ Assisted ☐ Complete	☐ Hair Care _____ ☐ Skin Care _____ ☐ Oral Hygiene _____ ☐ Dentures ☐ Upper ☐ Lower ☐ Nails _____	☐ Self ☐ Peri-Care ☐ Diapers ☐ Commode ☐ BM Frequency Q _____

Diet: _____ **Allergies:** _____

* Attach copy of current diet orders.

Sensory Assessment: ☐ No limitations ☐ Hearing Impairment ☐ Visual Impairment

Mental Status: ☐ Alert/Oriented To Time, Place and Person ☐ Confused ☐ Wanders

Disoriented To: ☐ Time ☐ Place ☐ Person ☐ Situation

History of Seizures: Describe _____

Mental Health: ☐ Hallucinations ☐ Delusions ☐ Withdrawn ☐ Depressed ☐ Angry ☐ Agitated

☐ Harming Others ☐ Other: _____

Level of Care Assessment: LOC Assessment Obtained: ☐ Yes ☐ No

Resident Certified: ☐ Independent Living ☐ ARCH ☐ ICF ☐ SNF

☐ Self Preservation Obtained

The resident ☐ is ☐ is not

capable of following directions and taking appropriate action for self-preservation under emergency conditions.

Social Summary:

Physician Name: _____ Telephone #: _____

Appointments: Next Due: _____ ☐ Once a Month ☐ 2-3 times per Month ☐ 4+ times per Month

Psychiatrist Name: _____ Telephone #: _____

Appointments: Next Due: _____ ☐ Once a Month ☐ 2-3 times per Month ☐ 4+ times per Month

Medical Plan: _____ Insurance #: _____

Case Manager Name: _____ Telephone #: _____

Legal Guardian Name: _____ Telephone #: _____

Nearest Relative Name: _____ Telephone #: _____

Address: _____

Power of Attorney Name: _____ Telephone #: _____

Transportation Needs: ☐ Bus ☐ Handi-Van ☐ Family ☐ Primary Caregiver

☐ Other: _____

Name of ARCH: _____

Signature of Primary Caregiver: _____ Date: _____

Signature of Receiving Agency: _____ Date: _____