INTER-AGENCY REFERRAL

Date/Time:	Diagnosis/Surgery and Date:
Reason for Referral:	
Pertinent History:	

Transferred from:	Transferred to:	Mode of Transfer:
☐ Dr.: ☐ Agency: ☐ Home Care:	☐ Dr.: ☐ Agency: ☐ Home Care:	☐ Car ☐ Ambulance ☐ Other:

Identification Arm Band on - ☐ NA ☐ Yes ☐ No *(why)*

Health Care Directives ☐ Advance Care Plan ☐ Goals of Care orders completed *(Describe):* ☐ Feeding Restrictions ☐ Medication Restrictions
☐ Other restrictions ☐ Code Status:
☐ Financial Power of Attorney ☐ Legal Medical Substitute Decision Maker
☐ Palliative Care ☐ Organ Donation ☐ Autopsy Request **Copies attached ☐ Yes ☐ No**

Key Contact – Name/Relationship:
Notified: ☐ Yes
☐ No
Tel #: Home: Work: Cell:

Allergies: (*list and describe reactions)* ☐ None Known
☐ Drug:
☐ Food:
☐ Environment:
☐ Facility specific Allergy/Intolerance record completed (if applicable)

Equipment with patient: ☐ No ☐ Yes *(If yes, list)*
Return equipment to -

Personal belongings with patient: ☐ Yes ☐ No *(If no, where?)*
Hearing Aid(s) ☐ Rt ☐ Lt ☐ Glasses ☐ Contact lens
Denture(s) ☐ Upper ☐ Lower ☐ Caps ☐ Partial
☐ Other:

Reports with patient: ☐ No ☐ Yes *(If yes, check boxes)*
☐ X-ray *(type)* ☐ Lab ☐ ECG
☐ Chart
☐ Other: (*list)*

Copies of attached
☐ AAH
☐ ICP
☐ MDS
☐ Physician Notes
Consult/History/Other

PH

Bath:
☐ Dependent
☐ Assist
☐ Self

Type of bath

Special skin care

Oral care:
☐ Dependent
☐ Assist
☐ Self

ELIM

Bladder:
Continent: ☐ Yes ☐ No
Regime:

Type/size of Catheter
Last Change
Change Due

Bowel: Continent: ☐ Yes ☐ No Last bowel care/BM
Regime:
Next bowel care due

NUTR

Feed:
☐ Dependent
☐ Assist
☐ Self

Type of Diet
☐ Tube feed

Diet restrictions, dislikes, special feeding devices
☐ **Copy of Swallowing Assessment**
☐ **Supplies arranged with the Receiving agency**

MOB

Mobilize:
☐ Dependent
☐ Assist
☐ Self
☐ Bariatric needs *(describe)*

Type and extent of devices and assistance required
Copy of ☐ Physiotherapy ☐ OT
☐ **Copy of Mobility Assessment**
☐ **Receiving Agency aware of Bariatric Needs**

OBSERVATIONS AND MEASUREMENTS

T	P	R	BP	SaO_2	Pain (0-10)	Blood Glucose	Ht	Wt	Intake	Output	LMP

Normal Findings
☐ CNS
☐ CVS
☐ Resp
☐ GI
☐ GUR
☐ Integ
☐ MS
☐ EENT
☐ ENDO

Abnormal findings: (*describe)*

Systems Assessment

Other Observation and Measurements:

☐ **Pain Management Record**

White – with patient **Yellow – patient record**

INTER-AGENCY REFERRAL

MEDICATIONS

IV Therapy

No. 1 – Solution:	**No. 2 –** Solution:	
Flow rate:	Flow rate:	
Additive:	Additive:	
Initiated at:	Initiated at	
Amount absorbed:	Amount absorbed:	
Needle Size/Site:	Needle Size/Site	
Comments:	Comments:	

Current Medications
Own Meds with Pt. ☐ Yes ☐ No

Comments
☐ Copy of current Medication Records attached ☐ Reconciled
☐ Medication Administration Record
☐ Receiving Agency aware of Medication needs

TX AND PRO

Current treatments and/or procedures
Dressings: ☐ Simple ☐ Complex - Location(s):
Packing ☐ Yes ☐ No *(If Yes, describe including count)*
☐ Oxygen at _____l/min per ☐ Nasal cannula ☐ Simple Mask ☐ NRB mask ☐ Other:
Tubes/Peripheral Catheters: *(describe)*

☐ See attached Wound Record
☐ Wound Supplies arranged
☐ Oxygen Supplies arranged

☐ Practitioner orders/discharge instructions provided to home care

Infection Control ☐ Precautions required (c*heck and describe)*
☐ C.Diff ☐ Hepatitis ☐ Other:
ARO Screening: ☐ No ☐ Yes *(if yes, check and describe including date and results)* ☐ VRE ☐ MRSA ☐ Other:
Date of last TB test ☐ Negative ☐ Positive

☐ Receiving Agency notified
☐ EMS notified
☐ Public Health notified

Immunization History: ☐ Known ☐ Not Known Type/dates
Other Tx and Pro:

TEACHING

☐ Pt/caregiver understands reason for transfer
☐ Limitations to understanding *(describe)*
☐ Other
☐ Handout given *(name and dept)*

☐ Cost of transfer discussed and ambulance info provided

S

Risk for: ☐ Falling ☐ Wandering ☐ Climbing side rails ☐ Harming self ☐ Harming others ☐ Aggression

PS

Emotional Status *(Include patient's/family's reaction to transfer and understanding of condition)*
☐ Suicidal tendencies
☐ Communication difficulties: ☐ Dysphasia ☐ Language ☐ Other:
☐ Substance misuse: ☐ Drugs ☐ Alcohol ☐ Other:

Religious/Ethnic aspects of care

Appointments: Name	Location	Date/Time	Telephone

Home Care Services: ☐ Requested ☐ Provided

☐ Nursing Care ☐ Personal Care ☐ Home Maintenance ☐ Meals ☐ Respite ☐ Palliative Care
☐ Occupational Therapy ☐ Physiotherapy ☐ Social Services ☐ Social Worker ☐ Mental Health ☐ Other

The Information on the Inter-agency Referral has been:
☐ Verbal Nurse to Nurse Report (Required) ☐ completed
The information was reported to:
☐ Receiving Nurse Name _____ Phone _____

Transfer Information: ☐ Sent with patient ☐ Faxed to Receiving Unit – Fax #: _____
Comments related to transfer:

Sending Nurse Signature and Title

Print Name and Title

Phone

White – with patient **Yellow – patient record**