### INTER-AGENCY REFERRAL

#### Date/Time:

#### Diagnosis/Surgery and Date:

#### Reason for Referral:

#### Pertinent History:

#### Transferred from:
- Dr.:  
- Agency:  
- Home Care:  

#### Transferred to:
- Dr.:  
- Agency:  
- Home Care:  

#### Mode of Transfer:
- Car  
- Ambulance  
- Other:  

#### Identification Armband:
- NA  
- Yes  
- No  

#### Health Care Directives:
- Advance Care Plan  
- Goals of Care orders completed  
- 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:  

#### Equipment with patient:
- No  
- Yes  

#### Personal belongings with patient:
- Yes  
- No  

#### Allergies:
- None Known  
- Drug:  
- Food:  
- Environment:  

#### Reports with patient:
- X-ray  
- Lab  
- ECG  

#### PH Bath:
- Dependent  
- Assist  
- Self  

#### Elimination Bladder:
- Continent:  
- No Regime:  

#### Nutrition Feed:
- Dependent  
- Assist  
- Self  

#### Mobilization:
- Dependent  
- Assist  
- Self  

#### Observations and Measurements:
- CNS  
- CVS  
- Resp  
- GI  
- GUR  
- Integ  
- MS  
- EENT  
- ENDO  

#### Other Observation and Measurements:

#### Report System:
- Normal Findings  
- Abnormal findings:  
- Systems Assessment  

#### Other:
- Pain Management Record  

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White – with patient  
Yellow – patient record  

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<table>
<thead>
<tr>
<th>No. 1 – Solution</th>
<th>No. 2 – Solution</th>
</tr>
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<tbody>
<tr>
<td>Flow rate:</td>
<td>Flow rate:</td>
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<td>Additive:</td>
<td>Additive:</td>
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<tr>
<td>Initiated at:</td>
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<td>Amount absorbed:</td>
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<tr>
<td>Needle Size/Site</td>
<td>Needle Size/Site</td>
</tr>
<tr>
<td>Comments:</td>
<td>Comments:</td>
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</tbody>
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**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 [ ]

**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)

- Practitioner orders/discharge instructions provided to home care

**Infection Control**

- [ ] Precautions required (check 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

**Immunization History**

- [ ] Known [ ] Not Known [ ]
- Type/dates

**Other Tx and Pro:**

- [ ] Practitioner understands reason for transfer
- [ ] Limitations to understanding (describe)
- [ ] Other
- [ ] Handout given (name and dept)

**The Information on the Inter-agency Referral has been:**

- [ ] Verbal Nurse to Nurse Report (Required) [ ] completed

**Transfer Information:**

- [ ] Sent with patient [ ] Faxed to Receiving Unit – Fax #: __________

**Comments related to transfer:**

**Religious/Ethnic aspects of care**

**Appointments:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
<th>Date/Time</th>
<th>Telephone</th>
</tr>
</thead>
</table>

**Home Care Services:**

- [ ] 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

**Transfer Information:**

- [ ] Sent with patient [ ] Faxed to Receiving Unit – Fax #: __________

**Comments related to transfer:**

**White – with patient**

**Yellow – patient record**