**REFERRAL INFORMATION**

**Location of Appointment,**  
**Date, and Time:**

**Reason for Referral:**

**Pertinent History:**

<table>
<thead>
<tr>
<th>Referral Request</th>
<th>Referred by</th>
<th>Mode of Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Test:</td>
<td>☐ Dr. (Name)</td>
<td>☐ Car</td>
</tr>
<tr>
<td>☐ Consult:(Name)</td>
<td>☐ Nurse</td>
<td>☐ Taxi</td>
</tr>
<tr>
<td>☐ Diagnostic Imaging</td>
<td>☐ Clinic</td>
<td>☐ Ambulance</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Other</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

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

**Health Care Directives** *(describe)*
- ☐ Living Will
- ☐ Advanced Directive
- ☐ Feeding Restrictions
- ☐ Medication Restrictions
- ☐ Other restrictions
- ☐ Power of Attorney/Medical Proxy in place
- ☐ Palliative Care
- ☐ Organ Donation
- ☐ Autopsy Request

**Copies attached** ☐ Yes ☐ No

**Key Contact** – Name/Relationship:
Notified: ☐ Yes ☐ No

**Equipment with patient:** ☐ Yes (If yes, list) ☐ No

**Personal belongings with patient:** ☐ Yes ☐ No (If no, where?)

**Hearing Aid(s):** ☐ Rt ☐ Lt ☐ Glasses ☐ Contact lens

**Denture(s):** ☐ Upper ☐ Lower ☐ Caps ☐ Partial ☐ Other:

**Copies of attached**
- ☐ AAH
- ☐ ICP
- ☐ MDS
- ☐ Mobility Assessment
- ☐ Wound Record

**PERSONAL HYGIENE** ☐ NA ☐ Comments

**ELIMINATION** ☐ NA ☐ Comments

**NUTRITION** ☐ NA ☐ Comments ☐ Last intake

**MOBILITY** ☐ NA ☐ Comments

**Observations and Measurements** ☐ NA ☐ Comments

T-________ P-________ R-________ BP-________ Pain (0-10)________ Blood Glucose________

**SaO2-________ Hr-________ Wt-________**

**Current Medications**

<table>
<thead>
<tr>
<th>DOSE</th>
<th>ROUTE</th>
<th>FREQ</th>
<th>LAST TAKEN</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Comments**

**Copy of Medication Record Attached**

**TREATMENTS AND PROCEDURES** ☐ NA ☐ Comments

- Dressings ☐ Yes *(describe)* ☐ No
- Packing ☐ Yes *(describe)* ☐ No
- Infection Control Precautions Required ☐ Yes *(describe)* ☐ No

**Teaching** *(indicate as applicable)*
- ☐ Pt/caregiver understands reason for referral
- ☐ Limitations to understanding *(describe)*

**Safety** *(Indicate as applicable)*

- Risk for: ☐ Falling
- ☐ Climbing side rails
- ☐ Harming self
- ☐ Aggression
- ☐ Other

- Wandering
- ☐ Harming others
- ☐ Other

- ☐ Suicidal tendencies
- ☐ Communication difficulties: ☐ Dysphagia
- ☐ Language
- ☐ Substance misuse: ☐ Drugs ☐ Alcohol
- ☐ Other

**Date:** __________  
**Time:** __________  
**Signature:** __________  
**Print Name:** __________

Verbal Nurse to Nurse Report completed in the event of unscheduled appointments ☐ Yes ☐ No. Receiving Nurse Name __________

**Comments from Referral Institution**

Comments: __________

**Copies sent with Patient:**
- ☐ Outpatient Record
- ☐ Medication Reconciliation Audit
- ☐ Consultant Record
- ☐ Lab Report
- ☐ Other

**Signature:** __________

**Print Name:** __________

Verbal Nurse to Nurse Report completed prior to the patient’s return ☐ Yes ☐ No. Receiving Nurse Name __________

**Date:** __________  
**Time:** __________