REFERRAL INFORMATION

Location of Appointment, Date, and Time:

Reason for Referral:

Pertinent History:

Referral Request:	**Referred by:**	**Mode of Transport:**
☐ Test:	☐ Dr: (Name)	☐ Car
☐ Consult:(Name)	☐ Nurse	☐ Taxi
☐ Diagnostic Imaging:	☐ Clinic	☐ Ambulance
☐ Other	☐ Other	☐ Other:

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
Tel #: Home: Work: Cell:

Allergies: (*list and describe reactions*) ☐ None Known

Equipment with patient: ☐ Yes *(If yes, list)* ☐ No
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: ☐ Yes *(If yes, check boxes)* ☐ No
☐ X-ray *(type)*
☐ Lab
☐ ECG
☐ Other: *(list)*
☐ Physician Notes Consult/History/Other
☐ Chart

PERSONAL HYGIENE ☐ NA ☐ Comments

ELIMINATION ☐ NA ☐ Comments

NUTRITION ☐NA ☐ Comments ☐ Last intake_____

MOBILITY ☐ NA ☐ Comments
☐ Dependant ☐ Assist ☐ Self

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

OBSERVATIONS AND MEASUREMENTS ☐ NA ☐ Comments

T-_____P-_____R-_____BP-_____ Pain *(0-10)*-_____ Blood Glucose_____
SaO_2-_____Ht-_____Wt-_____

CURRENT MEDICATIONS	**DOSE**	**ROUTE**	**FREQ**	**LAST TAKEN**	**YES**	**NO**	**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 ☐ Wandering
☐ Climbing side rails
☐ Harming self ☐ Harming others
☐ Aggression ☐ Other

PSYCHOSOCIAL *(Indicate as applicable)*
☐ 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**

WHITE - On patient's record **YELLOW - Return to Referring Institution** **PINK - Remains at Referral Institution**