

### Care Home Transfer Form

<b>Name</b>		<b>Address</b>	
<b>DOB</b>			
<b>CHI</b>			
		<b>Tel</b>	
<b>** TO BE COMPLETED BY CARE HOME AT POINT OF ADMISSION **</b>			
<b>SITUATION</b> – <i>(reason for admission to hospital)</i>			
<b>BACKGROUND –</b>			
DNACPR: Yes No			
AWI: Yes No POA / Guardian details :			
Allergies : Yes No Details : _____			
Significant Past Medical History :			
NOK Name and Contact Number			
1. _____			
2. _____			
NOK Aware of admission Yes / No			
<b>ASSESSMENT –</b>			
Living with cognitive impairment		YES / NO	
Change in cognitive function in last 48 hours		YES / NO	
<b>Communication Needs</b>			
Speech	Yes / No	Details _____	
Hearing	Yes / No	Details _____	
Visual	Yes / No	Details _____	
<b>Personal Care and Dressing</b>			
Independent / Assistance of 1 / Assistance of 2			
Fully Continent / Incontinent of Urine / Incontinent of faeces / Doubly Incontinent			
Catheter Yes / No Date of insertion / reason for insertion _____			
<b>Eating and Drinking Requirements</b>			
Normal Diet: Yes / No / Nil By Mouth / Modified Diet: Level: 1 / 2 / 3 / 4 / 5 / 6			
Normal Fluids: Yes / No / Modified Fluids Level: 1 / 2 / 3 / 4		Supplements prescribed: Yes / No	
MUST score: _____		Dietitian Input: Yes / No	
Food Allergies Yes / No			
<b>Mobility</b>			
Bed Rest / Independent / Assistance 1 / Assistance 2			
Equipment Used : Zimmer / stick / hoist details _____			
<b>Skin Integrity</b>			
Any wounds Yes / No		Waterlow Score : _____	
Details (wound type / grade / location) : _____			
Equipment used at home : _____			
<b>RECOMMENDATIONS</b> <i>(any other information will help the hospital to care for this resident)</i>			
<b>Completed by Name / Designation :</b> _____			
<b>Date :</b> _____			

**Care Home Transfer Form**

<b>Home Safe - Discharge Check List for Ward Staff</b>		<b>Name/ Designation</b>
<b>Communication</b>	<b>Care Provider aware of planned date of discharge</b>	
	Comments:	
	<b>NOK aware of planned date of discharge</b>	
	Comments:	
	<b>Handover given to Care Home / Care Provider</b>	
Comments:		
<b>Prescriptions / Consumables</b>	<b>7 days dressing supplies</b>	
	Comments:	
	<b>7 days catheter / stoma supplies 14 days of incontinence products</b>	
	Comments:	
	<b>28 days of prescribed medication</b>	
Comments:		
<b>Personal Belongings</b>	<b>Dentures</b>	
	<b>Hearing Aids</b>	
	<b>Glasses</b>	
	<b>Walking Aids</b>	
<b>Documentation</b>	<b>IDL</b>	
	Comments:	
	<b>DNACPR / AWI / Anticipatory Care Plan / TEP</b>	
	Comments:	
	<b>Care Plans / Risk assessments share with Care Home</b>	
	Comments:	
	<b>IPC infection status (inc. outstanding results)</b>	
	Comments:	
<b>Catheter Passport</b>		
Comments:		
<b>Transport</b>	<b>Transport arranged</b>	
	Comments:	
	<b>Notify Care Home when patient leaves ward</b>	
Comments:		
<b>Safety Check</b>	<b>IV access removed</b>	