LTC Transfer/Discharge Summary

Transferred from:					Date of Transfer:								
					Cont	tact Num	ber	:					
Care Recipient Name:					ı	Date of Birth (dd/mm/yy):							
Reason for Tra	nsfer:												
Modical Diagn	osis/Hoolth Cor	ditions: list :	nrimary dia	anosis first	Curre	nt probl	omc				D	ate of onset	
iviedicai Diagn	osis/Health Cor	iditions: list p	primary dia	agnosis iirsi	./Curre	ent probi	ems				Do	ate of onset	
Vital signs & time taken	BP:	Pulse:	Pulse: Temp:			Resp Rate:			Wt: E		Sugar:	Pain rating:	
Allergies :	☐ Medicat	Medications:				☐ Food:							
Diet:	☐ Regular	☐ Soft	☐ Pure	ee 🗆 S	pecial:								
Dental Status:	☐ Own tee	Own teeth Upper dentures (with patient-Y/N)			☐ Lower dentures (with patient-Y/N)			☐ Bridge/partial			☐ No teeth		
Skin integrity:	☐ Intact				Stage	III L	Stage Location:			:			
Cognitive State	Cognitive Status Oriented to time, persons and/or place? If not, specify:												
GCS score & date:					Mini Mental Score & date:								
Advanced Care	e directives:	□ No	☐ Yes an	d indicate:	☐ F	ull Code		□ DNF	₹	☐ Dir	ectives a	ittached	
			, , ,					_				nondonco	
ADLe	Indonandant	SUPARVICION	a/vorhal			Physical a	ccic	tanca			Total da		
ADLs	Independent	Supervisior prompts or		I perso		2 perso			person + li		Total de	pendence	
ADLs Mobility	Independent	prompts or		I perso		Physical a 2 perso			person + li		Total de		
		-	cueing	I perso		_					Total de		
Mobility	·	prompts or	cueing			2 perso					Total de		
Mobility Bathing Eating Toileting		prompts or	cueing			2 perso					Total de		
Mobility Bathing Eating Toileting Assistive	Type and use:	prompts or	cueing			2 perso					Total de		
Mobility Bathing Eating Toileting Assistive Devices:		prompts or	cueing			2 perso					Total de		
Mobility Bathing Eating Toileting Assistive	Type and use:	prompts or	cueing			2 perso					Total de		
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription	Type and use:	prompts or	cueing		on	2 perso	on			ft	te & tim		
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser	Type and use: Sent with patie	prompts or	cueing		on	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser	Type and use: Sent with patie	prompts or	cueing		on	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser	Type and use: Sent with patie	prompts or	cueing		on	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser	Type and use: Sent with patie	prompts or	cueing		on	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser	Type and use: Sent with patie	prompts or	cueing		on	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser by a \)	Type and use: Sent with patient or N) Medication- ont with patient or N)	prompts or prompts or posage Power of A	Route	Frequen	су	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser by a)	Type and use: Sent with patient (or N) Person: NOK proxy OTHI	prompts or prompts or posage Power of A	Route	Frequen	cy e:	2 perso	on	1;		ft	te & tim	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser by a \)	Medication- nt with patient (or N) erson: NOK proxy OTHI Yes No	prompts or prompts or posage Power of A	Route	Frequen	ccy e:	2 perso	Pur	1 p		Da	te & time	e of last dose	
Mobility Bathing Eating Toileting Assistive Devices: Specific Care preferences/ needs: Prescription (indicate if ser by a Y	Type and use: Sent with patient (or N) Proxy OTHI Yes No No Prov	prompts or prompts or pent? Y/N Dosage Power of A ER: ider: □HIP	Route Attorney	Frequen	ccy e:	2 perso	Pur	1 p		Da	te & time	e of last dose	

If additional space is required:

Prescription Medications	1				Date & time of last dose
(continued) (indicate if sent with patient	Dosage	Route	Frequency	Purpose	given
by a Y or N)					