LTCH/RH – ED TRANSFER COMMUNICATION FORM

Please complete this form for all resident transfers from long-term care (LTC) and retirement home (RH) to the emergency department (ED). If the resident discharged directly from the ED (i.e. not admitted) then the ED is responsible for completing Section 3 to communicate the care plan back to LTC/RH. Form feedback or questions can be directed to Parisa Mehrfar (pmehrfar@msh.on.ca) / (905) 472-7373 ext.6394.

Section 1 – Prefilled Resident Information: For LTC/RH to have completed and checked regularly to ensure updated
Section 2 – Acute SBARD Assessment: For LTC/RH to complete upon calling 911 for transfer to ED
Section 3 – ED Transfer Back to LTC/RH: For completion by ED physician or nurse for discharge from ED

SECTION 1 – PREFILLED RESIDENT INFORMATION

Sent From (Name of Home): ______

☐ Long Term Care ☐ Retirement Home

Phone Number: ______

Resident Demographics (affix label here)

First Name: ______
Last Name: ______
DOB: ______
Sex: ______ Unit/Bed#: ______

Code Status: ☐ DNR ☐ Full Code **Cultural/Religious Considerations:** ______

Speaks English: ☐ Yes ☐ No, specify primary language: ______

Medical Diagnoses: ☐ A. Fib ☐ Cancer (specify below) ☐ CHF ☐ CKD ☐ COPD ☐ Dementia
☐ Diabetes ☐ HTN ☐ Mental Health (specify below) ☐ MI/IHD ☐ Seizures ☐ Stroke/TIA ☐ UTI
☐ Other: ______

Allergies: ☐ No Known Allergies ☐ Yes, specify: ______

LHIN Home and Community Support: ☐ No ☐ Yes, Case Manager: ______

Usual Mental Status

☐ Alert, oriented, follows instructions
☐ Alert, disoriented but CAN follow simple instructions
☐ Alert, disoriented CANNOT follow simple instructions
☐ Not alert

Usual Level of Function

(I=independent, D=dependent, A=needs assistance)

☐ Bathing
☐ Dressing
☐ Toileting/Transfers
☐ Eating
☐ Ambulation
☐ Cane ☐ Walker ☐ Wheelchair ☐ Hoyer Lift

Devices

☐ IV/PICC line ☐ Ostomy
☐ Pacemaker/ICD
☐ Foley catheter, size: ______
☐ G-tube, size: ______
☐ Other: ______

☐Glasses ☐ Hearing Aids ☐ Dentures

Continence

Bladder ☐ Yes ☐ No
Bowel ☐ Yes ☐ No

Diet: ______

Safety/Behaviour Concern

☐ Falls Risk ☐ Wandering ☐ Physical Aggression
☐ Other: ______

Last updated:

Name	Date	Name	Date

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LTC/RH – ED TRANSFER COMMUNICATION FORM

Patient Name: ______

SECTION 2 – ACUTE SBARD ASSESSMENT

LTC/RH staff to complete prior to resident transfer to ED

Name of physician ordering transfer: ______ ☐ N/A

Situation/ Background

Reason(s) for Transfer: ☐ Altered Mental Status ☐ Shortness of Breath ☐ Fever ☐ Chest Pain ☐ Hyper/Hypoglycemia ☐ Abdominal Pain ☐ Weakness ☐ Injury/Fall ☐ Behavioural Issues ☐ Other: ______

Please provide details of reason(s) for transfer below

Medication given prior to transfer:
☐ No ☐ Yes, specify: ______

POA/SDM Notified of Transfer? ☐Yes ☐No
Name of POA/SDM: ______
Phone #: ______

Code Status: ☐ DNR ☐ Full Code

COVID Status: ☐ Swab Pending ☐ COVID+ ☐ Facility on outbreak ☐ Other: ______

Assessment/ Recommendations

Vital Signs: P: _____ BP:_______ RR: _______ T:_____
BS: _____ Sat: ____% ☐ RA ☐ O2 ____ L/min

Physical Exam Findings: ______

Skin Integrity
☐ Intact
☐ Wound, specify below

☐ **Treat/Investigate as per ED Assessment**

Further investigations (specify)
☐ X-Ray ☐ US ☐ CT ☐ MRI ☐ ECG ☐ Blood/Urine test ☐ Referral
☐ COVID Swab
Other: ______

Documents

Personal Belongings sent with Resident: ______

Documents sent from facility with resident to the ED
☐ Point Click Care Transfer Form
☐ Face Sheet/Summary Sheet
☐ DNR-C Form
☐ Medical History & Medication List
☐ Lab and Radiology Reports in the last month
☐ Medication Administration Record
☐ Additional Notes: ______

☐ **ED received verbal report of transfer** (MSH ED 905-472-7003, Uxbridge ED 905-852-9771 x5261)
Verbal report received by: ______ Time: ______

Name of Person Completing Form: ______
☐MD ☐NP ☐RN/RPN
☐PSW ☐Other, specify: ______

Date/Time: ______

Phone #: ______ **Fax #:** ______

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LTC/RH – ED TRANSFER COMMUNICATION FORM

Patient Name: ____________________

SECTION 3 – ED TRANSFER BACK TO LTC/RH

** ED staff please either complete (A) hospital transfer forms or (B) complete this page and send back with resident upon discharge**

☐ **A) HOSPITAL TRANSFER FORMS COMPLETED**

- ☐ Hospital ED Transfer Checklist/SBARD Completed by Nurse
- ☐ Hospital ED Physician Discharge Summary Completed by Physician

OR

☐ **B) BELOW TRANSFER FORM COMPLETED**

Physician

Name of ED Physician: ____________________

Summary of Diagnosis/Primary Findings/Treatments: ____________________

____

New/Changes in Medications	Dose/Frequency/Route	1st Dose Given	Next dose due	Rx written

Follow-Up Appointments/Investigations/Instructions: ____________________

____

____

Labs/Tests Pending: ☐ No ☐ Yes, specify: ____________________

☐ Discharge plan discussed with POA/SDM, details: ____________________

____

Nurse

Records Sent with Patient or Faxed to Receiving Facility:

☐ Lab/Radiology Reports ☐ ECG ☐ ED Treatment Sheet ☐ This Form

Last Vitals

P:_____ BP:_____ RR:____ T:____ BS: ____ Sat:_____ % ☐RA ☐O_2 _____L/min Time: ________

☐ **Facility received verbal report of care plan and discharge from ED**

Verbal report given by: ____________________

Verbal report received by: ____________ Date/Time Called: ____________

905-472-7373 | 381 Church Street, P.O. Box 1800, Markham, Ontario, L3P 7P3