Please use ID label or block print

RESIDENT / CLIENT TRANSFER FORM

SERVICE: _____

SURNAME: | **URN:**

GIVEN NAME:

DOB: | **SEX:**

DOA:

Resident/Client Status: ☐ High Care ☐ Low Care ☐ CACP/ EACH Package ☐ Rehabilitation/Young Disabled

Important Numbers

Transfer to: _____

Medicare Number: _____

Private Health Insurance No: _____

Pension Number: _____

Service Details

Service's Address: _____

_____

Phone Number: _____

Fax Number: _____

Next of Kin Details

Name of NOK: _____

NOK Address: _____

NOK Phone Number: _____

NOK aware of transfer? ☐ Yes ☐ No

GP Details

Resident/Client's GP: _____

GP's Phone Number: _____

GP's Fax Number: _____

GP aware of transfer? ☐ Yes ☐ No

Does the resident/client have: ☐ High ACAT ☐ Low ACAT ☐ N/A

Diagnosis: _____

Reason for transfer: _____

_____

Drug Alert Sticker (if applicable)

ALLERGIES:

_____

_____

_____

ALERTS:

☐ Dysphagia

☐ Falls Risk

☐ Other _____

Medications – *Please see attached photocopy of medication profile*

Cognitive/Emotional State – *attach relevant correspondence*

Past: _____ Present: _____

Diet/Fluids: _____ **Skin Integrity/Wounds:** _____

Mobility

☐ Independently ambulant
☐ Standby supervision only
☐ 1 person min assistance to transfer
☐ Bed/Chair hoist transfer *(specify hoist)*
☐ Standing Hoist ☐ Full Hoist
☐ Equipment *(specify)*

_____

Eating & Drinking

☐ Independent
☐ Supervise
☐ Assistance
☐ Full Assistance
☐ Nil by Mouth
☐ PEG

Showering

☐ Independent
☐ Supervise
☐ Assistance

Dressing

☐ Independent
☐ Supervise
☐ Assistance

Toileting

☐ Independent
☐ Supervise
☐ 1 Assistant
☐ 2 Assistance

Dentures

☐ Lower
☐ Upper
☐ None

Glasses

☐ Yes
☐ No

Faecal Continence

☐ Yes
☐ No

Bowels last open _____

Behaviours

☐ Very Aggressive
☐ Unpredicted Responses
☐ Restlessness

Urinary Continence

☐ Yes
☐ No
☐ Catheter in situ

Other Information: _____

_____

Prostheses: _____ Valuables: ☐ Ring ☐ Watch ☐ Other: _____

Documents: ☐ Yes ☐ No Xrays/Imaging: ☐ Yes ☐ No Equipment: _____

Name: _____ **Designation:** _____ **Date:** _____

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