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

Dentures
- ☐ Lower
- ☐ Upper
- ☐ None

Glasses
- ☐ Yes
- ☐ No

Behaviours
- ☐ Very Aggressive
- ☐ Unpredicted Responses
- ☐ Restlessness

Toileting
- ☐ Independent
- ☐ Supervise
- ☐ 1 Assistant
- ☐ 2 Assistance

Urinary Continence
- ☐ Yes
- ☐ No
- ☐ Catheter in situ

Faecal Continence
- ☐ Yes
- ☐ No

Bowels last open _____

Other Information: _____

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

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

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

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