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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02400B (01/2019) | | | | | | | | | | | | | | **STATE OF WISCONSIN** | | | | |
| **CLIENT TRANSFER LABELS**  **Assisted Living Facility and Hospital Interface** | | | | | | | | | | | | | | | | | | |
| * See DQA publication [P-02067, *Assisted Living Facility and Hospital Interface,*](https://www.dhs.wisconsin.gov/publications/p02067.pdf) *and instructions below.\** * **NOTE: This form contains protected personal identifying and personal health information.** | | | | | | | | | | | | | | | | | | |
| **ALF Transfer to Hospital**  (To be completed by ALF staff) | | | | | | | | | | | | |  | | **Hospital Discharge to ALF**  (To be completed by hospital staff) | | | |
| **Client Name:** | | | | |  | | | | | | | | **Admitting Client to Hospital**  *If discharging, skip to next section.* | | | |
| **Reason for Transfer to Hospital:** | | | | | | | | | | | |  | Call facility; notify of patient status (inpatient vs. observation). | | | |
|  |  | | | | | | | | | | | | Provide diagnosis and reason for admission. | | | |
| **Facility Name:** | | | | | |  | | | | | | | Send ALF admission “blue” packet to unit. | | | |
| **Level of Care:**  SNF  ALF  Independent Living | | | | | | | | | | | | | Ensure belongings go with client to unit. | | | |
| Other: | | |  | | | | | | | | | | **Discharging Client Back to ALF** | | | |
| **Client’s Wing/Unit:** | | | | | | | |  | | | | | Call ALF to notify of client’s expected return. | | | |
| **Direct Phone No.:** | | | | | | |  | | | | | | Provide POC to determine if ALF has capability to accept  client back (IV abx, dressing changes, etc.). | | | |
|  | | | | | | |  | | | | | |  | | | |
| **CODE STATUS:  DNR  DNI  Full Code** | | | | | | | | | | | | | HCPOA and/or family have been notified or  N/A | | | |
| **Baseline Behavior:**   Cooperative  Withdrawn | | | | | | | | | | | | | Exact location to transport client (building, wing, door, room): | | | |
| Disruptive  Agitated  Wanders | | | | | | | | | | | | |  | |  | |
| Other: | | |  | | | | | | | | | |  | |  | |
| **USUAL Mental Status:** | | | | | | | | | | | | | Preferred transport method: | | |  |
| Alert / Oriented to: | | | | | | | | |  | | | | Arrange transportation. | | | |
| Alert / Disoriented; can follow instructions | | | | | | | | | | | | | Prepare discharge packet contents; send in blue envelope: | | | |
| Alert / Disoriented; cannot follow instructions | | | | | | | | | | | | | Hospital D/C Transfer (AVS) Report | | | |
| **USUAL Transfer:**   Independent  Needs assistance | | | | | | | | | | | | |  | Physician note (if available) | | |
| Unable – Transfers with: | | | | | | | | | | |  | |  | Signed medication prescriptions | | |
| **HCPOA Paperwork:**  Activated  Not act.  Not on file | | | | | | | | | | | | |  | Signed prescription for DME orders | | |
| **Client’s Emergency/Legal Representative Contact:** | | | | | | | | | | | | |  | Signed ambulance transfer form | | |
| Name: | |  | | | | | | | | | | | Ensure belongings return with client. | | | |
| Phone No.: | | | | |  | | | | | | | | \* There are two transfer labels provided on this form; one for ALF staff to complete and one for hospital staff to complete after a client has been seen in the hospital.  ALF staff should preprint and attach to the front of a blue envelope packet. It is recommended that ALF staff prepare a blue envelope packet for each client so that it is readily available whenever a transfer to a hospital becomes necessary.  Participating hospitals should complete the hospital portion when the client returns to the ALF. The hospital staff should also call the ALF and provide a verbal report prior to the client’s return.  **Because of the need to protect the confidential information included in this form and the packet**, these materials are intended to be handed directly from one caregiver to another. If there are concerns about maintaining confidentiality, the transfer label can be attached to a blue sheet of paper and included in a sealed envelope to be given to hospital staff. | | | |
| Notified of Transfer to Hospital:  Yes  No | | | | | | | | | | | | |
| **Preferred Transportation Option Upon Return to Facility:** | | | | | | | | | | | | |
| Family  Taxi  Ambulance  Facility vehicle | | | | | | | | | | | | |
| **Medications:**  Manages own meds  MAR | | | | | | | | | | | | |
| **Belongings:**  Glasses  Hearing aids  Dentures | | | | | | | | | | | | |
| Other: | | | |  | | | | | | | | |
| **Pharmacy Name/Phone:** | | | | | | | | | |  | | |
| **Documents to Include in Transfer Packet:** | | | | | | | | | | | | |
| ALF Client Face Sheet  Progress notes (past 48 hrs.) | | | | | | | | | | | | |
| MAR  ALF capability form  Code status | | | | | | | | | | | | |
| POA Paperwork  H&P | | | | | | | | | | | | |