Patient name:

Date of birth:

Social Security #:

Form – B
INTERAGENCY NURSING COMMUNICATION RECORD

Purpose: To provide pertinent information for patients being discharged or transferred throughout the health care continuum.

Instructions: To be sent to the receiving facility upon discharge.

Discharge to: ❑ home health agency ❑ long term care ❑ rehabilitation ❑ outpatient services ❑ other:___________

Admit from: ❑ nursing home:________________________ ❑ assisted living ❑ other:_________________________

Allergies/Reactions (include medications, food, latex environmental etc.): ❑ No known allergies

____

____

Height: _______ ❑ cm ❑ inches **Weight:** ______ ❑ kg. ❑ lb. **Diabetes:** ❑ yes ❑ no

Pulse: _______ **Temperature:** _______ **Respiration rate:** _________ **Blood pressure:** ______________

Adult assuming care: ❑ N/A Name: ____

Relationship: __________________________ Phone #: (______)________________

Vision: ❑ adequate ❑ poor ❑ blind **Glasses/Contacts:** ❑ no ❑yes ❑ with patient

Hearing: ❑ adequate ❑ poor ❑ deaf **Hearing aid:** ❑ right ❑ left ❑ with patient

Dentures: ❑ full ❑ upper ❑ lower ❑ partial ❑ with patient

Mental status: ❑ alert ❑ confused ❑ unresponsive **Oriented:** ❑ person ❑ place ❑ time

Behavior: ❑ cooperative ❑ uncooperative ❑ wandering ❑ noisy ❑ aggressive

Communication: ❑ speaks ❑ writes ❑ gestures **Understanding:** ❑ speaks ❑ writes ❑ gestures

Language: ❑ English ❑ other: _______________ ❑ needs interpreter

Mobility aids: ❑ walker ❑ wheelchair ❑ cane ❑ other: __________________

History of falls: ❑ yes ❑ no **Fall risk:** ❑ yes ❑ no

ACTIVITIES OF DAILY LIVING (mark as appropriate)

Activities	Total Assist	Partial Assist	Self Care	Activities	Total Assist	Partial Assist	Self Care
Bathing				Bowel			
Dressing				Bladder			
Eating				Bowel incontinence: ❑ yes ❑ no			
Turning				Date of last bowel movement: _____________			
Transfers				Bladder incontinence: ❑ yes ❑ no Last urine void: _________			
Ambulating				Date Foley inserted/changed: _____________ time: ________			
Diet:_______________________				If Foley discontinued, date: ________________			

Type of infusion catheter: ❑ Peripheral IV ❑ PICC line **Dialysis access**: ___________________________

Type of central line: ____________________ insertion date: ______________ # Lumens: _________________

Isolation precautions: ❑ MRSA ❑ VRE ❑ C-Diff ❑ Tuberculosis ❑ other: _______________________

Date Influenza vaccine given: __________________ **Date Pneumococcal vaccine given**:______________

Physicians Involved in Care of Patient	
Physician Name	Procedure/Service

Patient aware of diagnosis: ❑ yes ❑ no, explain:

Family/Designee aware of transfer: ❑ yes ❑ no, explain:

DNR: ❑ yes ❑ no

Significant care issues/assessments [include psychosocial, fall interventions, Braden Score, full description of skin integrity including wounds, incision and ulcers – including size (length and depth), location, color, drainage, odor and stage, if pressure ulcer; dressing, tubes, aspiration risk special equipment, etc.]:

____

____

Signature/Title: ________________________ Print Name: ____________________ Date: _______ Time:______