# METROPOLITAN WASHINGTON AREA INTER-AGENCY REFERRAL TRANSFER FORM

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PATIENT NAME: | | MR #: | TRANSFERRING FACILITY: | | UNIT: | | |
| ADDRESS / APT: | | TEL #: | REFERRAL TO: | | | | |
| CITY: | STATE: ZIP: | | TEL #: | FAX #: | | | |
| DOB: AGE: | ☐ M ☐ F MARITAL STATUS: S M W D | SSN #: | MEDICARE ID #: | A & B | A | B | |
| RELATIVE / GUARDIAN: | | | MEDICAID ID & CODES: | | | | |
| RELATIONSHIP: | | TEL #: | OTHER INSURANCE NAME: | | TEL #: | | |
| ADDRESS / APT: | | | INSURANCE #: | | | | |
| CITY: | STATE: ZIP: | | DATE ADMITTED: | DATE DISCHARGED: | | | |
| ALLERGIES: | | | SKIN INTACT? ☐ Y ☐ N IF "N" (NO), SKIN CARE SHEET ATTACHED? | | | ☐ Y ☐ N | |
| PRIMARY DIAGNOSIS: | | | | | | | |
| SECONDARY DIAGNOSIS: | | | | | | | |
| VITAL SIGNS: | TEMP: | P: | R: | B / P: | R / L: | SIT / LIE / STAND | |
| CHIEF COMPLAINT: | | | | | | | |

| SERVICES | DESCRIPTION OF THERAPY | WEIGHT BEARING STATUS |
|---|---|---|
| ☐ PHYSICAL THERAPY | | ☐ NON-WEIGHT BEARING |
| ☐ OCCUPATIONAL THERAPY | | ☐ PARTIAL-WEIGHT BEARING |
| ☐ SPEECH THERAPY | | ☐ FULL-WEIGHT BEARING |
| ☐ RESPIRATORY THERAPY | | |
| ☐ COMPANION | | |
| ☐ DIALYSIS | FREQUENCY: LOCATION: | TEL #: |

| SELF-CARE STATUS: | | INDEP | ASSIST | UNABLE |
|---|---|---|---|---|
| ADLS | BED TO CHAIR | | | |
| | WALKING | | | |
| | STAIRS | | | |
| | WHEELCHAIR | | | |
| | CRUTCHES | | | |
| | WALKER | | | |
| | BATHE | | | |
| | DRESS | | | |
| | FEED | | | |
| | BRUSHING TEETH | | | |
| | SHAVING | | | |
| | TOILET | | | |
| | COMMODE | | | |
| | BEDPAN / URINAL | | | |
| | RX ADMIN | | | |
| | | | | |

| DISABILITIES | |
|---|---|
| TYPE | DESCRIBE |
| ☐ AMPUTATION | |
| ☐ PARALYSIS | |
| ☐ CONTRACTURES | |
| ☐ OTHER | |

| COMMUNICAT'NS | SOCIAL |
|---|---|
| ☐ UNABLE TO WRITE | ☐ WORKS IN GROUPS |
| ☐ UNABLE TO SPEAK | ☐ LONER |
| ☐ UNDERSTANDS SPEECH | |
| ☐ UNDERSTANDS ENGLISH | |
| ☐ IF NO, SPECIFY LANGUAGE | |
| ☐ READS | |
| ☐ OTHER | |

| SENSORY IMPAIRMENT | |
|---|---|
| TYPE | EXPLAIN |
| ☐ SPEECH | |
| ☐ HEARING | |
| ☐ VISION | |
| ☐ SENSATION | |
| ☐ OTHER | |

| MENTAL STATUS | |
|---|---|
| ☐ ALERT | ☐ ORIENTED |
| ☐ FORGETFUL | ☐ WANDERS |
| ☐ CONFUSED | ☐ SUNDOWNER |
| ☐ WITHDRAWN | ☐ DIFFICULTY SLEEPING |

| ELIMINATION | |
|---|---|
| ☐ OSTOMY | INCONTINENCE ☐ BLADDER ☐ BOWEL |
| CATHETER (URINARY) | SIZE: DATE: |
| DATE LAST BM | |

PATIENT NAME: _____ SSN: _____

| MEDICATIONS GIVEN DAY OF D/C | DOSE | FREQUENCY | MEDICATIONS GIVEN DAY OF D/C | DOSE | FREQUENCY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## PSYCHO - SOCIAL INFORMATION:

☐ NO PROBLEMS NOTED ☐ COOPERATIVE ☐ DEPRESSED / WITHDRAWN ☐ ANGRY / HOSTILE
☐ REPORTS MOOD SWINGS ☐ SLEEP DISTURBANCE ☐ AGITATED ☐ ANXIOUS
☐ FLAT AFFECT ☐ LACK OF EVIDENT SUPPORT SYSTEMS

**HYGIENE:** ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

**TRANSPORTATION ISSUES (if any):**

## EXPLAIN NECESSARY DETAILS OF CLIENT / FAMILY TEACHING:

DIABETES:

WOUND:

MEDICATIONS:

NUTRITION / DIET / C-TUBE:

OSTOMY:

ADL / MOBILITY / TRANSFERS:

OTHER:

ADDITIONAL INFO:

| | | |
|---|---|---|
| PERSONAL BELONGINGS AND EQUIPMENT | ☐ WITH PATIENT ☐ TO FAMILY | EYESIGHT: ☐ CONTACT LENS ☐ EYEGLASSES<br>DENTURES: ☐ FULL ☐ UPPER ☐ LOWER<br>ASSISTIVE DEVICE:<br>HEARING AID: ☐ LEFT ☐ RIGHT<br>PROSTHESIS (Type): |

☐ CODE STATUS:
☐ ADVANCED DIRECTIVES ____ YES ____ NO ☐ SENT WITH PATIENT ____ YES ____ NO
☐ COPY OF MOST RECENT EKG SENT WITH PATIENT
☐ TB ____ NEGATIVE ____ POSITIVE ☐ STS ____ NEGATIVE ____ POSITIVE

| PRINTED NAME: | SIGNATURE | PHONE: | DATE: |
|---|---|---|---|
| | | | |

PATIENT NAME: _____ SSN: _____

## SKIN STATUS

***CLASSIFICATION of PRESSURE ULCERS: Adapted from AHCPR GUIDELINES***

**STAGE I:** NONBLANCHABLE ERYTHEMA OF INTACT SKIN, THE HERALDING (BEGINNING) LESION OF SKIN ULCERATION. IN INDIVIDUALS WITH DARKER SKIN, DISCOLORATION OF THE SKIN, WARMTH, EDEMA, INDURATION OR HARDNESS MAY ALSO BE INDICATORS.

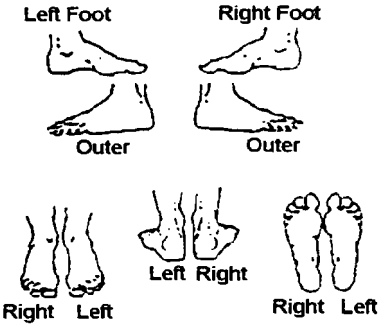
**STAGE II:** PARTIAL THICKNESS SKIN LOSS INVOLVING EDIMERMIS, DEMIS, OR BOTH.

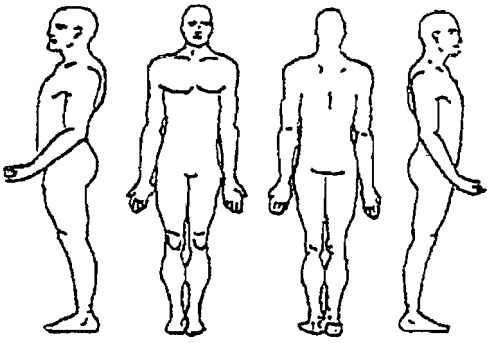
**STAGE III:** FULL THICKNESS SKIN LOSS INVOLVING DAMAGE TO OR NECROSIS OF SUBCUTANEOUS TISSUE THAT BY EXTEND DOWN TO, BUT NOT THROUGH, UNDERLYING FASCIA. THE ULCER PRESENTS CLINICALLY AS A DEEP CRATER WITH OR WITHOUT UNDERMINING ADJACENT TISSUE.

**STAGE IV:** FULL THICKNESS SKIN LOSS WITH EXTENSIVE DESTRUCTION, TISSUE NECROSIS, OR DAMAGE TO MUSCLE, BONE, OR SUPPORTING STRUCTURES (E.G., TENDOR OR JOINT CAPSULE).

**UNSTAGED:** WOUND BED COVERED WITH NECROTIC TISSUE

NUMBER EACH PRESSURE ULCER AND RECORD CHARACTERISTICS UNDER PRESSURE ULCERS DESCRIPTION CHART BELOW



## PRESSURE ULCER CHART

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PRESSURE ULCER # | | | | | | | | | | | | | | | | |
| STAGE | | | | | | | | | | | | | | | | |
| SIZE [ L x W x D ] | | | | | | | | | | | | | | | | |
| CRANULATION TISSUE | | | | | | | | | | | | | | | | |
| DRAINAGE | | | | | | | | | | | | | | | | |
| ODOR | | | | | | | | | | | | | | | | |
| TUNNELING | | | | | | | | | | | | | | | | |
| UNDERMINING | | | | | | | | | | | | | | | | |
| ESCHAR | | | | | | | | | | | | | | | | |
| SLOUGH | | | | | | | | | | | | | | | | |
| TREATMENT | | | | | | | | | | | | | | | | |
| ETIOLOGY FOR NON PRESSURE ULCERS | | | | | | | | | | | | | | | | |


## CURRENT TREATMENT

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **A** | = | DEBRIDING AGENTS | **D** | = | ALGINATES | **G** | = | SILVADENE CREAM |
| **B** | = | TRANSPARENT FILM | **E** | = | HYDROGEL | **H** | = | NSS W / D |
| **C** | = | HYDROCOILOID | **F** | = | FOAMS | **I** | = | OTHER |