Nursing Home to Hospital Transfer Data List

INTERACT®
Version 4.0 Tool

This list is intended to provide guidance on key data elements critical for safe and effective care at the time of transition to an acute care hospital. It is not intended to be comprehensive. The INTERACT **Nursing Home – Hospital Transfer Form** illustrates an example of how these data can be formatted so that the data are readily accessible for receiving clinicians.

Information to be Sent Immediately at the Time of Transfer

Contact Information

- ☐ Resident name
- ☐ DOB
- ☐ Language
- ☐ Date of admission
- Type of stay
  - ☐ Long term care
  - ☐ Skilled nursing facility
- ☐ Primary diagnosis for admission

Facility Information

- ☐ Name of hospital sent to
- ☐ Date of transfer

Nursing Home Information

- ☐ Contact person at nursing home
- ☐ Phone number

Contact Person Information

- Relationship
  - ☐ Relative
  - ☐ Health care proxy
  - ☐ Guardian
- ☐ Contact number

Primary Care Clinician in Nursing Home

- ☐ Name
- ☐ Contact number

Code status

- ☐ Full Code
- ☐ DNR (Do Not Resuscitate)
- ☐ DNI (Do Not Intubate)
- ☐ DNH (Do Not Hospitalize)
- ☐ Comfort Care Only
- ☐ Uncertain

Key Clinical Information

- ☐ Reason for Transfer
- Primary reason for transfer diagnostic testing only:
  - ☐ Yes
  - ☐ No

Relevant Diagnoses

- ☐ CHF
- ☐ COPD
- ☐ CRF
- ☐ DM
- ☐ Ca (*active treatment*)
- ☐ Dementia
- ☐ Other

Vital Signs

- ☐ BP
- ☐ HR
- ☐ RR
- ☐ Temperature
- ☐ O2 Saturation
  - ☐ Time taken
- ☐ Most recent pain level
  - ☐ Pain location
- ☐ Most recent pain med
  - ☐ Date given
  - ☐ Time given

Usual Mental Status

- ☐ Alert, oriented, follows instructions
- ☐ Alert, disoriented, but can follow simple instructions
- ☐ Alert, disoriented, cannot follow simple instructions
- ☐ Not Alert

Usual Functional Status

- ☐ Ambulates independently
- ☐ Ambulates with assistive device
- ☐ Ambulates only with human assistance
- ☐ Not ambulatory

Additional Clinical Information

- ☐ SBAR Acute Change in Condition Note included
- ☐ Other clinical notes included
- ☐ Date of last tetanus (*for residents with lacerations/wounds)*

Devices and Treatments

- ☐ Oxygen
  - ☐ Liters per minute
- ☐ Nasal cannula
- ☐ Mask
  - ☐ Chronic
  - ☐ New
- ☐ Nebulizer Therapy
  - ☐ Chronic
  - ☐ New
- ☐ CPAP
- ☐ BiPAP
- ☐ Pacemaker
- ☐ IV
- ☐ PICC line
- ☐ Bladder (Foley) Catheter
  - ☐ Chronic
  - ☐ New
- ☐ Internal Defibrillator
- ☐ Enteral Feeding
- ☐ TPN
- ☐ Other

Isolation Precautions

- ☐ MRSA
  - ☐ Site
- ☐ VRE
  - ☐ Site
- ☐ C. difficile
- ☐ Norovirus
- ☐ Respiratory virus/flu
- ☐ Other

Allergies

- ☐ Yes
- ☐ No

Risk Alerts

- ☐ Anticoagulation
- ☐ Falls
- ☐ Pressures ulcer(s)
- ☐ Aspiration
- ☐ Seizures
- ☐ Harm to self or others
- ☐ Restraints
- ☐ Limited/non-weight bearing:
  - ☐ Left/Right
- ☐ May attempt to exit
- ☐ Swallowing precautions
- ☐ Needs medications crushed
- ☐ Other

Personal Belongings Sent with Resident

- ☐ Eyeglasses
- ☐ Hearing Aid
- ☐ Dental Appliance
- ☐ Jewelry
- ☐ Other

Form Completed By

- ☐ Name
- ☐ Title
- ☐ Signature

Report Called By

- ☐ Name
- ☐ Title

Report Called To

- ☐ Name
- ☐ Title
- ☐ Date
- ☐ Time

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Information Not Critical for Emergency Room Evaluation: Can be forwarded later if unable to complete at time of transfer

Nursing Home Contact
- ☐ Name
- ☐ Title
- ☐ Phone number

Social Worker
- ☐ Name
- ☐ Phone Number

Family and Other Social Issues
- ☐ Yes
- ☐ No

Behavioral Issues and Interventions
- ☐ Yes
- ☐ No

Primary Goals of Care at Time of Transfer
- ☐ Rehabilitation and/or Medical Therapies with intent of returning home
- ☐ Chronic long-term care
- ☐ Palliative or end-of-life care
- ☐ Receiving hospice care
- ☐ Other

Treatments and Frequency
- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Transfusions
- ☐ Radiation
- ☐ TPN
- ☐ Other

Diet
- ☐ Needs assistance with feeding
- ☐ Trouble swallowing
- ☐ Special Consistency
- ☐ Enteral Feeding
  - ☐ Formula
  - ☐ Rate

Skin/Wound Care
- ☐ Pressure Ulcers
  - ☐ Stage
  - ☐ Location
  - ☐ Appearance
  - ☐ Treatments

Immunizations
- ☐ Influenza
  - ☐ Date
- ☐ Pneumococcal
  - ☐ Date

Physical Rehabilitation Therapy
Resident is receiving therapy with goal of returning home
- ☐ Yes
- ☐ No

Physical Therapy
- ☐ Yes
- ☐ No

Occupational Therapy
- ☐ Yes
- ☐ No

Speech Therapy
- ☐ Yes
- ☐ No

ADLs
- ☐ Bathing
- ☐ Toileting
- ☐ Dressing
- ☐ Eating
- ☐ Transfers
- ☐ Can ambulate independently
- ☐ Assistive device
- ☐ Needs human assistance to ambulate

Impairments General
- ☐ Cognitive
- ☐ Speech
- ☐ Hearing
- ☐ Vision
- ☐ Sensation
- ☐ Other

Impairments Musculoskeletal
- ☐ Amputation
- ☐ Paralysis
- ☐ Contractures
- ☐ Other

Continence
- ☐ Bladder
- ☐ Bowel
  - ☐ Date of last BM

Additional Relevant Information
- ☐ Yes
- ☐ No

Form Completed by
- ☐ Name
- ☐ Title
- ☐ Date
- ☐ Time
- ☐ Signature

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