Date Completed: / /

**ASSISTED LIVING RESIDENT TRANSFER CHECKLIST**

|  |
| --- |
| Resident Name**:**  DOB: / / |

Facility Information

|  |
| --- |
| Name of Facility Transferred From: Facility Phone Number: Facility Address: Facility Contact Name: Facility Cell Phone Number: Email Address: |

Medical Contact Information, DNR, HIPAA Release

|  |
| --- |
| Primary Care Physician: Phone Number: |
| Authorized Representative or Power Of Attorney(POA): Phone Number: |
| * Copy of Advanced Directives OR Do Not Resucitate (DNR) (ORANGE FORM) OR Portable Orders for Life-Sustaining Treatment (POLST), Attached * Copy of Face Sheet, Attached * Copy of HIPAA (Health Insurance Portability and Accountability Act) Release, Attached |

Medication Information

|  |
| --- |
| * Resident Receives Medication Services:  Yes  No  Self-administration |
| * Copy of Medication Administration Record (MAR) or Med List containing dosages and administration Attached |
| Current Pharmacy Name: Phone Number:  Address: |

Resident’s Known Basic Physical and Mental Conditions, and Basic Medical History Provide Dates of Recent Events, if Known

|  |  |
| --- | --- |
| * Has Dentures □Upper □Lower □Partials | * Has eyeglasses: |
| * Has Hearing Aid □ Left □Right | * Has diabetes: |
| * Cardiovascular Event: | * Pacemaker: |
| * Isolation Precautions: | * Cerebrovascular Event: |
| * Frequent Falls: |  |
| Alert and Oriented to:  Person  Place  Time Situation | |
| Allergies:  Yes, describe below  No  Reference Face Sheet  Unknown   * Medication * Additives * Preservatives * Latex or Adhesives * Other Known Allergies | |

Complete at time of emergency

|  |
| --- |
| **Reason(s) Emergency Response Requested**:  Name of staff and date: |
| **Notification to Authorized Representative** |
| * Advised authorized representative of name and address of hospital resident will be transferred to per the emergency medical professional.. * Authorized Representative Contacted By: Name: Date: |