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:
 |