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 Resuscitate (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: ________________