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 POA: _____Phone Number: _____
☐ Copy of Advanced Directives OR DNR (ORANGE FORM) OR POLST, Attached
☐ Copy of Face Sheet, Attached
☐ Copy of HIPAA 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 EMT.
☐ Authorized Representative Contacted By: Name: _____ Date: _____