



UNPLANNED TRANSFER ASSESSMENT

DEMOGRAPHIC INFORMATION

Name _____ Age _____

Room # _____ Unit _____

I.D.# _____

Date of last admission to the Nursing Facility _____

Payer: Medicare / Medicaid / Managed Care / VA / EverCare / Private Insurance

TRANSFER DETAILS

Nurse (RN/LPN) involved in transfer _____

Supervisor on Duty (RN/LPN) _____

Date of Transfer _____ Time of Transfer (AM/PM)

Was patient sent by EMS (911)? Yes / No

**What was not available in order to assess or treat the individual in the facility?
(Check and specify)**

- Diagnostic services _____
- Equipment _____
- Staff _____
- Other _____

EFFORTS TO HANDLE SITUATION WITHOUT TRANSFER

What was done to try to assess and treat in the facility? (Check)

- Physician on-site evaluation / Nurse practitioner on-site evaluation
- Practitioner in-depth telephone discussion
- Intravenous or subcutaneous fluids

- Lab tests _____
- X-rays
- Other tests (describe) _____
- EKG, rhythm strip
- Administer medications (describe)
- Other _____

FACTORS LEADING TO TRANSFER DECISION

Reason(s) for Hospital Transfer (check all that apply)

- Medical instability** (e.g., unstable vital signs, seizures, change in mental status, etc.)

Please specify:

- Physician** (e.g., MD insisted, MD unavailable)
- Ethical Issues** (e.g., no or incomplete advance directive)
- Family issues** (e.g., family insisted, family in conflict)
- Other** _____

Who authorized the transfer? (Select and identify by name)

Attending Physician / On-Call Physician / Nurse Practitioner / Medical Director

Other _____

Was the individual admitted to the hospital? Yes / No

Reason (s) for Transfer (check all that apply)

- Fever
- Altered mental status
- Dehydration/decreased po intake
- Pneumonia or lower respiratory infection
- UTI
- Heart Failure

- COPD
- Injury (describe) _____
- GI – nausea, vomiting, diarrhea
- Skin infection (e.g., cellulites, infected pressure ulcer)
- Psychiatric (e.g., agitation, psychosis, suicidal ideation)
- Suspected DVT
- Other (describe) _____

DETERMINATION OF AVOIDABILITY

Based on review, hospital transfer was: Avoidable / Possibly Avoidable / Unavoidable

Signature of Person Completing Form _____

Date of completion _____

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