Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

NATIONAL TRANSFER DOCUMENT AND HEALTH PROFILE FOR RESIDENTIAL CARE FACILITIES

The Health Profile, up to date copy of Medication List and Administration Record of the person being transferred, should accompany this document. Please ensure that these and any other relevant information is attached. All documentation regarding transfer to be completed with the resident in so much as possible.

Section A	**Priority 1: THINGS THAT YOU MUST KNOW ABOUT ME** This Section should be completed at time of transfer	
ISBAR$_3$ Communication Framework (*Based on NCG No.11, NCEC, DOH, 2015 and NMPD DML, 2018)		
I	**Identify:** Identify yourself, who you are talking to and who you are talking about	
	Recipient of Information *(Please circle):* e.g Hospital/Staff (ED) or Staff (MAU), Paramedics	
	GP Name:	GP Number:
	Referred by: e.g. GP, GP Out of Hours, Nurse in charge	Seen by GP *(Please circle)*: Y/N
	At present the resident is receiving care in:	
	Unit Name :	Unit Telephone Number:
	Health Mail Address of Unit/ Email Address of Unit:	
	Nurse in Charge of Unit:	Key worker *(If applicable):*
	Named Designated Representative/ Contact Person (including wards of court):	
	Designated Rep/Contact Person notified of transfer *(Please circle)*: Y/N	Phone Number:
	Medical Card *(Please circle):* Y/N	Health Insurance *(Please circle)*: Y/N
	Religion / Spiritual Needs:	Ethnicity:
S	**Situation:** What is the current situation/change in condition, concern, observations etc? Why am I (resident) being transferred?	
	Brief summary of resident's current status/identification of the problem requiring transfer (including suspected delirium)	

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B	**Background**: Summary of Treatment to Date, Relevant Medical/Surgical History, Vital Signs (Please complete with resident if possible)
	MY MEDICAL INFORMATION
	Have I (resident) been involved in the decision to transfer me to hospital? (*Please circle):* Y/N If no, please state reason:
	A copy of my medicines prescription is attached *(Please circle):* Y/N
	Do I present as acutely confused *(Please circle):* Y/N Do I present with symptoms of pain*:* Y/N
	Do I present with a choking risk (*Please circle*): Y/N *(Please see eating and drinking in my health profile)*

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	My bowels last opened Time__:__ Date __/___/___ I last passed urine Time__:___ Date ___/__/___	
	I use breathing support (*Please circle as appropriate*): BiPap NIV LTOT Please provide details:	
	I have a history of adverse drug reactions/ allergies *(Please circle):* Y/N If Yes please specify:	
	I have a history of adverse other reactions/ allergies *(Please circle):* Y/N e.g. (anaphylaxis, medication allergy, food allergies and/ or intolerances *etc.*) *(Please give details including what my reactions would be)*	
	I have an Advanced Health Care Plan/ Directive *(Please circle):* Y/N/ copy attached I have an End of life care plan dated and attached: *(Please circle):* Y/N Active Safeguarding Concerns *(Please circle):* Y/N (*If Yes Please Contact Residential Care Setting*)	
	I **currently** have a health-care associated infection *(Please circle):* Y/N/Unknown *If known please circle* : HCAI/ MDRO/ BBV[1] status, Influenza, Norovirus, Hep B, Hep C, HIV, *Clostridium difficile*, MRSA, CPE/ CPE contact, VRE, COVID-19	I have **a history** of a health-care associated infection status *(Please circle):* Y/N/Unknown *If known please circle* : HCAI / MDRO/ BBV[2] status, Influenza, Norovirus, Hep B, Hep C, HIV, *Clostridium difficile*, MRSA, CPE, VRE , COVID-19 **Other** *(Please specify):*

[1] HCAI= Healthcare- associated Infection/ MDRO= Multi- drug Resistant Organism / Blood- Borne Virus= Hepatitis B, Hepatitis C, Human Immunodeficiency Virus

[2] HCAI= Healthcare- associated Infection/ MDRO= Multi- drug Resistant Organism / Blood- Borne Virus= Hepatitis B, Hepatitis C, Human Immunodeficiency Virus

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	I received my COVID-19 Vaccination: 1st Vaccine: Date __/___/___ 2nd Vaccine: Date __/___/___ Booster Vaccine: Date __/___/___	Date of positive HCAI/ MDRO/ BBV3 status, Influenza, Norovirus, Hep B, Hep C, HIV, Clostridium difficile, MRSA, CPE/ CPE contact, VRE, COVID-19 result: I received my: Influenza Vaccine: Date __/___/___ Pneumococcal Vaccine: Date __/___/___
	Other *(Please specify):*	
	I have been informed of my HCAI/ MDRO/ BBV status (*Please circle):* Y/N	**Eradication / screening protocol attached** (If relevant)*(Please circle):* Y/N
	SUMMARY OF TREATMENT TO-DATE	

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

	RELEVANT MEDICAL/SURGICAL HISTORY/KEY MEDICAL INFORMATION					
	VITAL SIGNS					
	Recorded by:		**Time recorded:**			
	B.P.	**Pulse Rhythm** Regular / Irregular	**Pulse Rate**	**Temperature**	**Respiratory Rate:**	
	O_2 Sat (R/A):	**O_2 Sat** (O_2 therapy):	**Blood Sugar:**	**GCS:**	**AVPU**	**Other:**
A	**Assessment: What is the problem/your assessment of the situation?**					
R	**Recommendation, Read-back, Risk**					
	Specify your (nurse) clinical recommendations					
	Identify possible risks					
	Date and time:	Signature:	Print Name			

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

Checklist of Supporting Documentation	***Please attach Health Profile**
Health Profile	Y/N
Medication List	Y/N
Medication Administration Record	Y/N
End of Life Care Plan *(If applicable)*	Y/N
Advance Care Plan/Directive *(If applicable)*	Y/N
Medical Transfer Letter	Y/N
Enteral Feeding Regimen *(If applicable)*	Y/N
Healthcare Associated Infection Protocol	Y/N
List accompanying equipment :	
Other relevant information: Please state:	

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

Section B MY HEALTH PROFILE

My Personal Preferences

MY NAME IS:

I WANT TO BE CALLED:

MY DATE OF BIRTH __ /__/____

I CURRENTLY RESIDE AT (Nursing Home/Community Hospital)

WHAT I WANT YOU TO KNOW ABOUT MY IDENTITY (e.g. Gender)

IMPORTANT PEOPLE IN MY LIFE:

WHEN I SEEK ADVICE, I ASK THE FOLLOWING PEOPLE:

HOW I RESPOND TO NEW ENVIRONMENTS OR EVENTS:

WHAT CAN BE DONE TO SUPPORT ME:

THINGS I LIKE: (e.g. what makes me happy, things I like to do, see or talk about)

THINGS THAT WORRY OR UPSET ME:

SPECIAL ITEMS I LIKE TO HAVE WITH ME

(e.g. pillow, blanket, photograph)

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

My Personal Preferences

MY SLEEP PATTERN

Usual bedtime:

Usual clothing:

Time of settling:

Time of waking:

You can help me settle by:

I usually sleep in bed *(Please circle):* Y/N

I usually have ____ pillows

I usually call out for assistance *(Please circle):* Y/N

I need a bell/I need an adapted bell *(Please circle):* Y/N

MENTAL HEALTH

How do I describe my mental well-being?

SMOKING

I smoke *(Please circle):* Y/N

If yes, how much daily?

I vape *(Please circle):* Y/N

ALCOHOL USE

I drink alcohol *(Please circle):* Y/N

If yes, how often and how much?

Resident Name _____Date of Birth_____Completed by_____ Date_____ PIN____

HOW I AM USUALLY

Please circle answers unless otherwise indicated

MY COMMUNICATION

My comprehension:

No Difficulty/ Mild / Moderate/ Severe

My expression:

No Difficulty/ Mild / Moderate/ Severe

My first language is: _____

I need an interpreter: Y/N

How to support me to communicate e.g. key phrases / terms for understanding/ communication board:

SIGHT: I wear glasses: Y/N

Other_____

HEARING: I wear hearing aids: Y/N

What aids are with me:

Spectacles/ Hearing aids/Dentures/ Assistive Technology/Communication boards

MY COGNITIVE FUNCTION

My cognitive score: *(Please circle relevant score)*

MMSE	/30	AMTS	/ 10,
MOCA	/30,	4AT	/12 (Max)
Date completed	/ /		Deficit Y/N

MY MOBILITY

Independent / Supervision

Assistance x1/ Assistance x2
Immobile/Wheelchair

Standing Hoist /Full Hoist

I have a mobility aid: Y / N

Walking Stick/ Frame/ 4 Wheeled Walker/

3 Wheeled Walker /Wheelchair

I am at risk of falls: Y/N

My most recent fall: Date __/___/___

My Functional Level: (Barthel /20)

Clinical Frailty Score:

(Specify scale used)

Other_____

MY SKIN INTEGRITY

Intact/ Grade 1/ Grade 2 /Grade 3 /Grade 4

(Please complete one scale below as appropriate)

Water low Score: 10+ (at risk), 15+ (high risk), 20+ (very high risk)

Braden Score: <11 (high risk), 12-14 (moderate risk), 15-16 (low risk), ≥17 (no risk)

Norton Score: _____

I use a pressure-relieving device: Y/N

(Please specify):

Wound location: *(If applicable)* _____

Dressing used :(*If applicable*)_____

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HOW I AM USUALLY

Please circle answers unless otherwise indicated

MY NUTRITION

I require assistance with eating/drinking: Y/N

Support I may need with eating/drinking *(please specify)*_____

My Foods & Drinks/ Modification Requirements: *(please circle)*

Level 0-Drinks (Thin),

Level 1-Drinks (Slightly Thick),

Level 2-Drinks (Mildly Thick),

Level 3-Drinks & Foods (Moderately Thick-Liquidised),

Level 4-Drinks & Foods (Extremely Thick- Pureed),

Level 5-Foods (Minced and Moist),

Level 6-Foods (Soft and Bite Sized),

Level 7-Foods (Easy to Chew/Regular)

If unsure, please describe:

Special diet: Y/N *(Please specify)*

Fluid restriction: Y/N

MY WEIGHT_____

Date recorded: __/___ /___

Any recent change: Y/N

Specify loss/gain:

M.U.S.T score:

I have a feeding tube in place: Y/N

If yes, Please indicate type:

Size: ___

Date last inserted: __ /__ /__

Regimen attached: Y/N

I wear dentures/bridges: Y/N

I have crowns/implants: Y/N

Foods & Drinks: Likes/Dislikes preferences

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HOW I AM USUALLY

Please circle answers unless otherwise indicated

MY NORMAL BOWEL PATTERN

I am continent: Y/N

I am not fully continent: Day/Night /N/A

Continence-wear type I use *(If applicable):*

How often I need to go to the toilet:

___ (hours)

I have a Stoma in place: Y/N

Equipment required:

MY NORMAL URINARY PATTERN

I am continent: Y/N

I am not fully continent: Day/Night /N/A

Continence-wear type I use *(If applicable):*

How often I need to go to the toilet:

___ (hours)

I have a urinary catheter in situ: Y/N

Last changed:__/__/_____**Size:**

Type: Urethral or Supra-pubic

I have a stoma in place: Y/N

Equipment required:

ADDITIONAL INFORMATION

Please let us know any further information that would help make your care more individual to your needs (e.g. What support I may require?)

HSE Office of the Nursing & Midwifery Services Director
UNIVERSITY OF LIMERICK OLLSCOIL LUIMNIGH
OLDER PEOPLE

The Development of a National Transfer Document for use when an older person is being transferred from Residential to Acute Care Settings

Funded by the Health Service Executive

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