Patient name:

Date of birth:

Social Security #:

Form - A
INTERAGENCY CLINICAL STATUS INFORMATION

Purpose: To provide pertinent clinical information when sending a long term care resident to the Emergency Department or for direct elective admission to hospital.

Date of status change:_____ Time: _____

Instructions: To be completed by nurse and sent along with the Face Sheet, Medication Administration Record and any other pertinent information. Side 1

SENDING FACILITY	RECEIVING FACILITY
Facility name: _____	Facility name: _____
Address: _____	Contact name:_____
Phone number: _____	

Name of physician notified: _____ Phone #: _____ Date: _____ Time: _____
Name of family notified: _____ Date: _____ Time: _____

Allergies/Reactions (include medications, food, latex environmental etc.): ❑ No known allergies

_____

_____

Isolation Precautions: ❑ MRSA ❑ VRE ❑ C-Diff ❑ Tuberculosis ❑ Other: _____

Risk: ❑ aspiration ❑ falls ❑ skin breakdown **Devices** (i.e. pacer): _____

Reason for transfer (Describe how the status of this resident has changed**):**_____

_____

Diet: _____

COM PLETE THIS SECTION FOR EMERGENCY DEPARTMENT (ED) ADMISSION ONLY

DETERMINED PRIOR TO ED VISIT TO ADDRESS CHANGE

VITAL SIGNS Date:_____ Time:_____
Temperature: _____ Pulse: _____
Respiration: _____ Blood pressure:_____

PAIN LEVEL: ❑ mild ❑ moderate ❑ severe
Pain location: _____
Time of last medication: _____

TEST	Date	Time	Results
❑ Urinalysis	_____	_____	Attached
❑ Pulse Oximetry	_____	_____	_____
❑ Initial Glasgow Coma Scale (if completed)	_____	_____	_____
❑ Blood Sugar			

If insulin given: Type: _____ Time: _____ Dose: _____

Date of last bowel movement: _____ Date of last urine void: _____

Any recent medication changes: ❑ No ❑ Yes, specify: _____

Resident is usually:

❑ alert & oriented x 3 ❑ alert but disoriented/confused ❑ poor alertness/somnolent
❑ agitated ❑ combative ❑ other:_____

TYPE OF CHANGE: (mark all that apply)

Respiratory/Cardiac:

❑ **Shortness of breath:** ❑ room air ❑ O_2 at: _____ *liters per minute:* ❑ Nasal Cannula ❑ Mask

❑ **Cough:** ❑ productive ❑ non-productive ❑ wheeze ❑ blood tinged sputum ❑ frank hemoptysis

❑ **Chest pain:** relieved with sublingual Nitroglycerin: ❑ Yes ❑ No ❑ palpitations

Change in Mental Status/Condition:

❑ disoriented/confused ❑ seizure activity ❑ decreased responsiveness

❑ agitated ❑ combative ❑ unresponsive ❑ other:_____

Patient Name:

Date of Birth:

Social Security #:

Form – A
INTERAGENCY CLINICAL STATUS INFORMATION

Side 2

TYPE OF CHANGE CONTINUED: (mark all that apply)

Fall: ❑ No ❑ Yes If yes, ❑ witnessed ❑ unwitnessed **History of falls**: ❑ No ❑ Yes, date of last fall: _____

Fell from: ❑ bed ❑ chair ❑ standing ❑ other:_____

Height of fall: _____ onto: ❑ carpet ❑ linoleum ❑ cement ❑ grass ❑ tile ❑ other:_____

Cause of fall, if known (slip, trip, dizziness, etc.): _____

Can resident recall fall? ❑ No ❑ Yes, resident's statement: _____

_____

Head injury: ❑ Yes ❑ No ❑ Unknown Loss of consciousness: ❑ Yes ❑ No ❑ Unknown

Resident on Anticoagulation/blood thinner therapy (Coumadin, Heparin, Aspirin, NSAIDS, Plavix, Lovanox): ❑ No ❑ Yes

If on Coumadin, date of last INR: _____ Results: _____

Other changes in condition: _____

Skin integrity status:_____

Recent Surgery (date & describe):_____

Recent Hospitalization (date & describe):_____

Resident has a history of:

- ❑ Alcohol abuse
- ❑ Asthma/Chronic Obstructive Pulmonary Disease
- ❑ Bleeding disorder/coagulopathy
- ❑ Cancer
- ❑ Chest pain/angina
- ❑ Chronic renal disease
- ❑ Congestive Heart Failure
- ❑ Constipation
- ❑ Deep vein thrombosis/ Pulmonary Embolism
- ❑ Delirium
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes
- ❑ Fever
- ❑ Gait/balance disorder
- ❑ Gastrointestinal bleeding
- ❑ Hypertension
- ❑ Liver disease
- ❑ Myocardial Infarction/Heart Attack
- ❑ Osteoporosis
- ❑ Parkinson's disease
- ❑ Pneumonia
- ❑ Postural hypotension
- ❑ Psychiatric disorder (specify):_____
- ❑ Recent infection
- ❑ Seizure disorder
- ❑ Stroke
- ❑ Syncope
- ❑ Urinary Tract Infection
- ❑ Other: _____

_____

Code Status/Hospital Status (mark as applicable):

❑ Full code ❑ Do not intubate ❑ Do not resuscitate ❑ Do not hospitalize (ED visit for acute care is permissible.)

❑ **Copy of Advance Directive / Living Will / Treatment Limitations/ DNR / DNH order form sent with resident if applicable.**

Sent with resident:

- ❑ Medication Administration Record
- ❑ History & Physical
- ❑ Face Sheet
- ❑ Electrocardiogram (EKG)
- ❑ Recent Labs
- ❑ Chest X-Ray
- ❑ Physician Progress Notes (last 3 dates)
- ❑ Nursing Progress Notes (last 3 dates)
- ❑ Other: _____

Signature/Title:_____ Print Name: _____

Unit Name: _____Phone #: _____ Date: _____