Patient name:

Date of birth:

Social Security #:

Form – B
INTERAGENCY NURSING COMMUNICATION RECORD

Purpose: To provide pertinent information for patients being discharged or transferred throughout the health care continuum.

Instructions: To be sent to the receiving facility upon discharge.

Discharge to: ❑ home health agency ❑ long term care ❑ rehabilitation ❑ outpatient services ❑ other:_____
Admit from: ❑ nursing home:_____ ❑ assisted living ❑ other:_____
Allergies/Reactions (include medications, food, latex environmental etc.): ❑ No known allergies
_____
_____
Height: _____ ❑ cm ❑ inches **Weight:** _____ ❑ kg. ❑ lb. **Diabetes:** ❑ yes ❑ no
Pulse: _____ **Temperature:** _____ **Respiration rate:** _____ **Blood pressure:** _____
Adult assuming care: ❑ N/A Name: _____
Relationship: _____ Phone #: (_____)_____
Vision: ❑ adequate ❑ poor ❑ blind **Glasses/Contacts:** ❑ no ❑yes ❑ with patient
Hearing: ❑ adequate ❑ poor ❑ deaf **Hearing aid:** ❑ right ❑ left ❑ with patient
Dentures: ❑ full ❑ upper ❑ lower ❑ partial ❑ with patient
Mental status: ❑ alert ❑ confused ❑ unresponsive **Oriented:** ❑ person ❑ place ❑ time
Behavior: ❑ cooperative ❑ uncooperative ❑ wandering ❑ noisy ❑ aggressive
Communication: ❑ speaks ❑ writes ❑ gestures **Understanding:** ❑ speaks ❑ writes ❑ gestures
Language: ❑ English ❑ other: _____ ❑ needs interpreter
Mobility aids: ❑ walker ❑ wheelchair ❑ cane ❑ other: _____
History of falls: ❑ yes ❑ no **Fall risk:** ❑ yes ❑ no

ACTIVITIES OF DAILY LIVING (mark as appropriate)

Activities	Total Assist	Partial Assist	Self Care	Activities	Total Assist	Partial Assist	Self Care
Bathing				Bowel			
Dressing				Bladder			
Eating				Bowel incontinence: ❑ yes ❑ no			
Turning				Date of last bowel movement: _____			
Transfers				Bladder incontinence: ❑ yes ❑ no Last urine void: _____			
Ambulating				Date Foley inserted/changed: _____ time: _____			
Diet:_____				If Foley discontinued, date: _____			

Type of infusion catheter: ❑ Peripheral IV ❑ PICC line **Dialysis access**: _____
Type of central line: _____ insertion date: _____ # Lumens: _____
Isolation precautions: ❑ MRSA ❑ VRE ❑ C-Diff ❑ Tuberculosis ❑ other: _____
Date Influenza vaccine given: _____ **Date Pneumococcal vaccine given**:_____

Physicians Involved in Care of Patient	
Physician Name	Procedure/Service

Patient aware of diagnosis: ❑ yes ❑ no, explain:

Family/Designee aware of transfer: ❑ yes ❑ no, explain:

DNR: ❑ yes ❑ no

Significant care issues/assessments [include psychosocial, fall interventions, Braden Score, full description of skin integrity including wounds, incision and ulcers – including size (length and depth), location, color, drainage, odor and stage, if pressure ulcer; dressing, tubes, aspiration risk special equipment, etc.]:

_____
_____

Signature/Title: _____ Print Name: _____ Date: _____ Time:_____