Transition Summary and Recapitulation Form

PATIENT NAME_____

CONTACT INFORMATION:

Patient's Address (Street, City, State, and Zip Code)_____

Patient's Phone Number _____

Name and Address of Responsible Party (if other than patient)_____

_____

Phone Number of Responsible Party (if other than patient)_____

Facility: _____ Phone Number: _____ Unit: _____

Physician Name: _____ Phone Number: _____

ADMISSION/TRANSITION INFORMATION:

Admission Time & Date: _____ Transition Time & Date: _____

Transition to ❒ Home ❒ Family Member's Home: _____Other location (specify): _____

Transition with ❒ Alone ❒ Family (specify): _____Other (specify): _____

Transition via ❒ Car ❒ Handicapped Van ❒ Ambulance ❒ Other (specify): _____

Reason for transition: ❒ Postacute Rehabilitation Complete ❒ Financial Reasons (Specify): ___

_____ ❒ Other: _____

<u>Referrals for Care:</u>

Pharmacy:

Name: _____ Phone #: _____

Contact person: _____

Home Healthcare Agency

Name: _____ Phone #: _____

Contact person: _____ Initial visit:_____

Meals on Wheels

Name: _____ Phone #: _____

Contact person: _____

Senior Citizens Agency

Name: _____ Phone #: _____

Contact person: _____

Equipment Vendor

Name: _____ Phone #: _____

Contact person: _____ Delivery Date:_____

Other: _____ Other: _____

Other: _____

PRIMARY DIAGNOSIS:

_____
_____
_____
_____
_____

IMPORTANT MEDICAL INFORMATION:

_____
_____
_____

INFECTION CONTROL:

❒ No infection ❒ Infection Type: _____

VITAL SIGNS AT TIME OF TRANSITION:

Height_____ Weight_____ Temperature_____ Pulse_____

Respirations_____ Blood Pressure_____

ALLERGIES (LIST ALL):

_____
_____
_____

ADVANCED DIRECTIVE:

❒ No

❒ Yes ❒ Living Will ❒ Attached

CODE STATUS

_____
_____

FOLLOW-UP

Contact your physician for an appointment: Call Dr. _____'s office at _____

The following appointments have been scheduled for you:

Dr. _____ on _____/_____/_____ at _____

Dr. _____ on _____/_____/_____ at _____

Dr. _____ on _____/_____/_____ at _____

DIET

Current diet: _____

Special instructions: _____

EQUIPMENT NEEDED UPON TRANSITION ❒Yes ❒No

❒Ordered Delivery Date:_____

❒ Gait aid (Specify type): _____ ❒ Wheelchair

❒ Bedside Commode ❒ Toilet Seat Riser ❒ Reacher ❒ Tub/Shower Bench

❒ Appliance/Splint (Specify): _____ ❒ Other (Specify):_____

❒ Other (Specify): _____

CURRENT PHYSICAL STATUS OF PATIENT

Skin:

❒ Intact

❒ Surgical Incision(s)

Location: _____

Color:_____ Drainage:_____

Treatment:_____

❒ Pressure Sore(s)/Ulcer

Location: _____

Stage: _____

Describe:_____

Treatment:_____

❒ Rash

Location: _____

Describe:_____

Treatment: _____

❒ Other (describe): _____

_____

❒ Specialty Bed

Type: _____

Special Treatments:

❒ None

❒ Oxygen: _____ Liters/min

❒ Tracheostomy:

❒ Old

❒ New

Type: _____

Care: _____

❒ Blood Glucose Monitoring

Frequency: _____

❒ Pain Management:

Intensity (Rate 0-10): _____

Location:_____

Treatments: _____

Medications: _____

_____

❒ Other: _____

_____

_____

SUMMARY OF STAY, RESPONSE TO TREATMENT AND PROGRESS TOWARD ACHIEVING GOALS:

Occupational Therapy: _____

_____

_____

_____

_____

_____

_____

_____

Recommendation for OT after transition: _____

Therapist signature: _____ Date: _____

Physical Therapy: _____

_____

_____

_____

_____

_____

_____

Recommendation for PT after transition: _____

Therapist signature: _____ Date: _____

Speech: _____

_____

Recommendation for Speech after transition: _____

Therapist signature: _____ Date: _____

Nursing: _____

_____

Nurse signature: _____ Date: _____

Social Services: _____

_____

Discharge Planner signature: _____ Date: _____

Other: _____

_____

Signature: _____ Date: _____

PATIENT/CAREGIVER EDUCATION RECORD:

X	Education Needs:	What was Taught and to Whom:	Date:	Instructions Attached (yes/no)
	Gait training/Transfers			
	Injection Technique			
	Diet/Nutritional Needs			
	Tube Feeding			
	Catheter Care			
	Wound/Incision Care			
	ADL Assistance			
	Infection Control Measures			
	Medication Instruction			
	Total Hip Education			
	Total Knee Education			
	Other			
	Other			

Nurse Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if other than patient): _____

Copy of Form Given To:

❒ Patient

❒ Home Health

❒ Family Member (specify): _____

❒ Responsible Party (specify): _____

❒ Copy not given (specify reason): _____

❒PCP (Doctor in the community) Name: _____

Address:_____

_____

Phone #: _____

CURRENT MEDICATIONS

Medication	Strength	Frequency	Reason for Medication	Date/Time of Last Dose