

Semiahmoo House Society Hospital Transfer



Individual's Name _____ Date of Birth _____ Personal Health Number _____

Allergies Yes No Describe: _____

Facility Name _____ Phone # _____ Facility Address _____

Home Contact _____ Phone # _____

Ministry of Children & Family Dev't Contact _____ Phone # _____

Next of Kin _____ Phone # _____

Degree of involvement _____

Person with signing authority _____ Phone # _____

Doctor _____ Phone # _____ Specialist _____ Phone # _____

Reason for Admission/Consultation _____

Pre-existing medical history _____

Date of last tetanus _____ Hep B Status _____

Medications: Copy of current & complete MAR or Medication Profile attached How taken (crushed etc.) _____

Diet: Swallowing difficulties: Yes No Describe _____

Eating: Independent Minor Assist. Major Assist. Describe _____

Method of Communication: Able to speak Read Hear Deficits _____

Mental Ability/behaviour: Confused Aggressive Wanders

Specific behaviours _____

Interventions _____

Ambulation/Transfer: Assistance/Aids _____

Describe and Distance _____

Dressing: Independent Minor Assist. Major Assist. Bathing: Independent Minor Assist. Major Assist.

Bladder Control: Continent Incontinent Bowel: Continent Incontinent

Toilet every _____ hrs. Date last B.M. _____

Skin Condition: Describe (rash, infection etc.) _____

Personal Effects Accompanying Individual: Hearing Aid Lt. Rt. Glasses Dentures Upper Lower Partial

Other _____

Safety Precautions Required _____

Cultural / Religious Issues _____

Individual enjoys _____

Individual's hobbies _____

Individual's fears _____

Contact for discharge planning _____

Form Completed By _____ Revision Date _____