RACF staff to complete

Facility name: _____
Wing/Unit: _____
Nurse: _____
Contact number: _____
☐ Permanent Resident ☐ Respite

Attach sticker here

Last name: _____
First name: _____
Date of birth: _____

Preferred name: _____

Envelope received by: ☐ QAS ☐ HHS

ALERTS

☐ **Allergies:** _____ ☐ **Infectious/MRO:** _____
☐ **Communication:** _____ ☐ **Implanted device:** _____
☐ **Mobility:** _____ ☐ **Other:** _____
☐ Interpreter Required. **Language spoken:** _____
☐ **Incontinence:** ☐ Faecal ☐ Urinary
☐ **Intake:** ☐ Diet: _____ ☐ Fluids: _____ ☐ Alternative: _____
☐ **Cognitive impairment:** ☐ Mild ☐ Moderate ☐ Severe
☐ **Skin Integrity:** ☐ Intact ☐ PI/Concern: _____
☐ **Challenging behaviour:** ☐ Physical ☐ Verbal

Checklist for transfer

Enclosed in the envelope is:

☐ Reason for transfer
☐ Usual functionality and observations / Identified risk, triggers and strategies
☐ Copy of current medication summary and signing sheets including PRN/short course
☐ GP health summary / Medical Assessment
☐ Other information e.g. pathology, x-rays
☐ Enduring power of attorney (EPOA), Adult guardian documentation *(circle as appropriate)*
☐ Advance Health Directive (AHD), Statement of Choices (SOC), End of Life Plan (EOL), Advance Resuscitation Plan (ARP) *(circle as appropriate)*
☐ Does not have advance care plan (ACP)

Contacts

GP

Aware of transfer? YES / NO

☐ Contact details enclosed
Time contacted: _____

Have you contacted your local RaSS Triage Support Team? *0437 173 358*

YES / NO

Time contacted: _____

Substitute Decision Maker

Aware of transfer? YES / NO

☐ Contact details enclosed

Is this person the EPOA? YES / NO

Time contacted: _____

Name: _____

Relationship: _____

Personal belongings

☐ **Dentures** ☐ Upper ☐ Lower ☐ Full
☐ **Glasses**
☐ **Hearing aid** ☐ Left ☐ Right

☐ **Mobility aids:** _____
☐ **Bag:** _____
☐ **Other:** _____
☐ **Valuables:** _____

This person is a resident of an aged care facility

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V1

Hospital staff to complete

Hospital: _____

Unit: _____

Direct phone: _____

Attach sticker here

Last name: _____

First name: _____

Date of birth: _____

Preferred name: _____

This person is a resident of an aged care facility

Envelope received by: ☐ **QAS** ☐ **RACF**

☐ **Intake:** ☐ Diet:_____ ☐ Fluids:_____ ☐ Alternative:_____

Notifications

GP

Aware of transfer? YES / NO

☐ Electronic discharge summary

☐ Fax ☐ Email

☐ Other: _____

Time contacted: _____

Name of person spoken with:

_____

RACF

Aware of transfer? YES / NO

Time contacted: _____

Name of person spoken with:

_____

Substitute Decision Maker

Aware of transfer? YES / NO

Time contacted: _____

Name of person spoken with:

_____

Discharge checklist *Note: bold items are mandatory*

Medical

☐ **Medical Discharge Summary/Letter**

Pharmacy

☐ Discharge Medication Record

☐ **IMAR / EDDMAR**

☐ Medication dispensed ☐ Script provided

☐ Supply amount given: _____

Nursing

☐ **Nursing care plan summary**

☐ Allied health summary

☐ **Copy of MAR / NIMC**

☐ Confirmed pharmacy and medical discharge enclosed

☐ Pressure injury check complete

☐ Wound care advice / instructions

☐ Lines, tubes, drains removed

Care planning

Care planning documents developed and enclosed:

☐ Advance Resuscitation Plan

☐ Other: _____

Personal belongings

☐ **Dentures** ☐ Upper ☐ Lower ☐ Full

☐ **Glasses**

☐ **Hearing aid** ☐ Left ☐ Right

☐ **Valuables:** _____

☐ **Mobility aids:** _____

☐ **Bag:** _____

☐ **Other:** _____

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