RACH staff to complete

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

Attach sticker here

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

Preferred name: _____

Envelope received by: ☐ QAS ☐ HHS **Date & Time:** _____

REASON FOR TRANSFER: _____

RASS/GEDI/GERI/AFTER HOURS SERVICE notified: YES/NO

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 behavious** ☐ Physical ☐ Verbal

Checklist for transfer **Enclosed in the envelope is:**

☐ 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
Date & time contacted: _____

Substitute Decision Maker
Aware of transfer? YES / NO
Is this person the EPOA? YES / NO
Name: _____
_____
☐ Contact details enclosed
Date & time contacted: _____
Relationship: _____

Personal belongings

☐ **Dentures** ☐ Upper ☐ Lower ☐ Full
☐ **Glasses**
☐ **Hearing aid** ☐ Left ☐ Right
☐ **Mobility aids:** _____
☐ **Bag:** _____
☐ **Other:** _____
☐ **Valuables:** _____

The information & documents in this yellow envelope are current at the time of transfer.

Date and time: _____ **Signature:** _____

CCQ COUNTRY TO COAST, QLD Healthy, connected communities
phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST An Australian Government Initiative

To order yellow envelopes: YellowEnvelope@c2coast.org.au August 2025

This person is a resident of an aged care home

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 home

Envelope received by: ☐ **QAS** ☐ **RACH** **Date:** _____

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

Notifications

GP

Aware of transfer? YES / NO

Date & time contacted: _____

Name of person spoken with: _____

☐ Electronic discharge summary

☐ Fax ☐ Email

☐ Other: _____

RACH

Aware of transfer? YES / NO

Date & time contacted: _____

Name of person spoken with: _____

Substitute Decision Maker

Aware of transfer? YES / NO

Date & 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:** _____

The information & documents in this yellow envelope are current at the time of transfer.

Date and time: _____ **Signature:** _____