

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

Date: _____

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
- 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)
- GP health summary / Medical Assessment
- Other information e.g. pathology, x-rays

Contacts

GP

Aware of transfer? YES / NO

Contact details enclosed

Time contacted: _____

Have you contacted your local RaSS Triage Support Team?

YES / NO

Time contacted: _____

Substitute Decision Maker

Aware of transfer? YES / NO

Is this person the EPOA? YES / NO

Name: _____

Contact details enclosed

Time contacted: _____

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

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 Date: _____

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: _____