RACF staff to complete

Facility name: _____

Wing/Unit: _____

Nurse: _____

Attach sticker here

Last name: _____

First name: _____

Date of birth: _____

Preferred name: _____

ALERTS

- ☐ **Allergies:** _____
- ☐ **Behaviour:** _____
- ☐ **Communication:** _____
- ☐ **Infectious:** _____
- ☐ **Implanted device:** _____
- ☐ **Other:** _____
- ☐ Interpreter Required. **Language Spoken:** _____
- ☐ **Diet:** ☐ Nil by mouth _____
- ☐ **Cognitive impairment:** ☐ Mild ☐ Moderate ☐ Severe
- ☐ **Mobility:** ☐ Independent ☐ Supervised ☐ 1 x Assist ☐ 2 x Assist ☐ Stick ☐ Walker ☐ Wheelchair ☐ Rollator

Checklist for transfer

☐ **Information available on My Health Record**

Enclosed in the envelope is:

- ☐ Reason for transfer
- ☐ Usual functionality and observations
- ☐ Copy of current signing sheet including PRN page
- ☐ 24 hours of medication sent with patient
- ☐ 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

☐ Contact details enclosed

Aware of transfer? YES / NO

Time contacted: _____

Hospital / CARE-PACT

Hospital: _____

Name of person spoken with: _____

CARE-PACT clinical pathway used? YES / NO

Aware of transfer? YES / NO

Time contacted: _____

Best contact

☐ Contact details enclosed

Name: _____

Relationship: _____

Aware of transfer? YES / NO

Time contacted: _____

Personal belongings

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

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V1

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

Swab/s completed prior to discharge: _____

Result: ☐ **Pos** ☐ **Neg** ☐ **TBC**

☐ **Information added to My Health Record**

Notifications

GP

Aware of transfer? YES / NO

☐ Electronic discharge summary

☐ Phone ☐ Email

☐ Fax ☐ Mail

Time contacted: _____

Name of person spoken with: _____

RACF

Aware of transfer? YES / NO

Time contacted: _____

Name of person spoken with: _____

Best contact

Aware of transfer? YES / NO

Time contacted: _____

Name of person spoken with: _____

Discharge checklist

Medical

☐ Medical discharge summary

☐ EDDMAR

Pharmacy

☐ Discharge medication summary

☐ IMAR

☐ Medication dispensed

Nursing

☐ Nursing summary

☐ Allied Health / CARE-PACT summary

☐ Medication administration record

☐ Confirmed pharmacy and medical discharge enclosed

☐ Pressure injury check complete

☐ Wound care

☐ IVC removed

Care planning

Care planning documents developed and enclosed:

☐ Advance Health Directive

☐ Statement of Choices

☐ Adult Guardian Order

☐ Advance Resuscitation Plan

☐ Advance Care Plan

☐ Other: _____

Personal belongings

☐ **Dentures** ☐ Upper ☐ Lower ☐ Full

☐ **Glasses**

☐ **Hearing aid** ☐ Left ☐ Right

☐ **Patient's own medication**

☐ **Mobility aids:** _____

☐ **Bag:** _____

☐ **Other:** _____

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