University Hospitals of North Midlands
NHS Trust

Hospital to Care Home

Transfer of Care

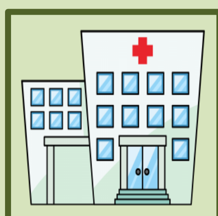
Patient Name:

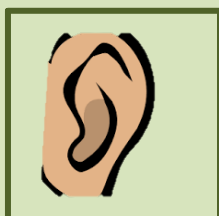
Unit Number:

NHS Number:

Care Home Name:

Care Home Telephone Number:





**THIS DOCUMENT IS TO STAY WITH THE PATIENT WHILE IN HOSPITAL &
RETURN TO THE CARE HOME WITH THEM**

Name:
Unit Number:

University Hospitals
of North Midlands
NHS Trust

SUMMARY OF ADMISSION TO HOSPITAL

REASON FOR ADMISSION/DIAGNOSIS	LATEST OBSERVATIONS Temp…………………… Pulse…………………… BP ……………………… Resp rate…………….. Blood sugar……………..
TREATMENT GIVEN	
DISCHARGE WEIGHT	MUST SCORE
	MEDICATION – ANY CHANGES TO MEDICATION REGIME (please document)

ALLERGIES (circle)	Yes	No	Not Known
Details:			

DNAR IN PLACE (circle)	YES	NO	IF NEW DNAR DATE FOR REVIEW	
ReSPECT IN PLACE (circle)	YES	NO	REVIEW DATE IF KNOWN	

REFERRALS MADE (Please circle) Add details if required	District Nurse Yes No Outpatient appointment Yes No Other Referral Yes No Therapies referral Yes No …………………………………………………………………………………… ……………………………………………………………………………………
Completed By	
Date/Time	
Sign	

THIS DOCUMENT IS TO STAY WITH PATIENT WHILE IN HOSPITAL & CARE HOME

NHS
University Hospitals of North Midlands
NHS Trust

24

48

24-48-HOURS AFTER ADMISSION TO WARD		
Contact home and reconfirm planning meeting	Yes Attending	Not Attending
If not attending provide reason and DOCUMENT PLANNING DISCUSSION		
Happy for return home when medically fit?	**Yes**	**No**
If No complete Profile	**Date completed**	

2 DAYS PRIOR TO EDD			
Contact made with home?	Yes	No	Contact Name:
Update on treatment plan Happy for return home	Yes		No
If no complete profile	Date completed		

DAY OF DISCHARGE PLAN – *Completed and outcome*				
TTO RECEIVED	GP LETTER COMPLETED	N2N COMPLETED (only needed for DN)	COMMUNITY SPECIALIST TEAMS CONTACTED	PROVISIONALLY BOOK TRANSPORT
Any medication supplied please list:				

ASSESSMENT OF ABILITY ON DISCHARGE

MOBILITY *(Circle)*						
Current status	Unaided	Stick	W/chair	Zimmer	1 Person	2 Person
Comments:						

IS THIS PATIENT AT A RISK OF FALLS? *(Circle)*			
Current status	Yes	No	Equipment
Comments:			

TRANSFERS IN/OUT OF BED *(Circle)*				
Current status	Unaided	1 Person	2 Person	Equipment
Comments:				

TRANSFERS IN/OUT CHAIR/TOILET *(Circle)*				
Current status	Unaided	1 Person	2 Person	Equipment
Comments:				

DRESSING/UNDRESSING *(Circle)*					
Current status	Unaided	Minimal Assistance	Full Assistance	1x Assist	2x Assist
Comments:					

PHYSIO/OT ASSESSMENT COMPLETED BY	
Name & Date	

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Name:
Unit Number:

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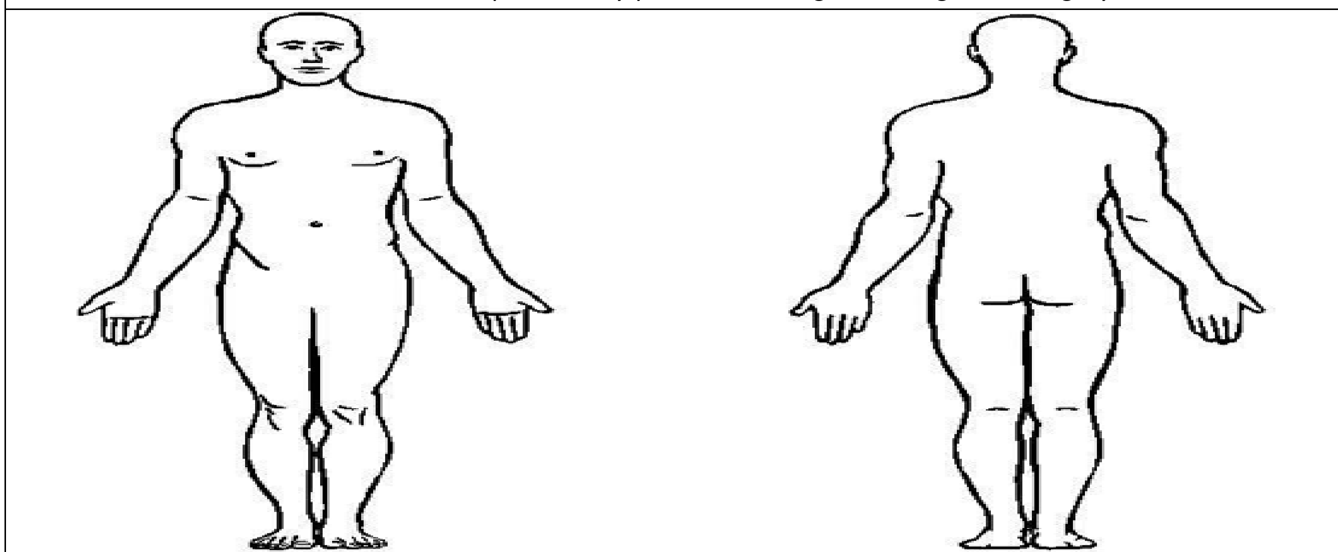
SKIN ASSESSMENT *(Circle)*				
Current status	Intact	Pressure Ulcer	Redness	Other
Any Changes since admission?		WATERLOW Score		
Plan and dressings used				
Please indicate on map areas any pressure damage, bruising and category				



DISTRICT NURSE REFERRAL IF APPLICABLE*(Circle)*		
Yes	Nameof Nurse /Practice:	Date of Visit
No	Telephone Number:	

INFECTION PREVENTION (*Circle)*						
Is the patient an infection risk ?	**Yes**			**No**		
If yes please circle	**MRSA**	**CDIFF**	**TB**	**ESBL**	**CPE**	**OTHER**
Details of results and treatments:						

ANY CHANGES TO BASELINE INFORMATION (WHATS NORMAL FOR ME) please detail below

ADDITIONAL INFORMATION

Completed By	
Date/Time	
Sign	