# HOSPITAL NURSING TRANSFER LETTER

## Hospital Nursing Transfer Checklist and Letter

- To be completed when any patient is being transferred from hospital to a care home or intermediate care bed
- To be included within the **Red Bag** prior to leaving hospital if a patient has one of these

**Wherever possible, this form should be completed electronically and printed. If your hospital does not have this functionality, please use this paper copy.**

| Date of **admission** to hospital: | | Date of **transfer (discharge)** from hospital: | |
|---|---|---|---|
| Patient's name: | Date of birth: | Gender: | NHS number: |

| **Social Worker info (if known):** | **Transfer information:** |
|---|---|
| Name: | Hospital and Ward name: |
| Contact details: | Ward telephone: |
| | Has the NOK been notified? Yes / No / NA |
| | Has the Care Home been notified? Yes / No / NA |
| **Care home details** | **Next of Kin information:** |
| Name: | Name: |
| Address: | Relationship: |
| Unit/floor: | Contact details: |

Is there a current **DOLS** in place? Yes / No

Is there a named **IMCA** or **Advocate**? Yes / No

If yes, provide a name and contact details:

Are there any **ongoing safeguarding** concerns? Yes / No

Comments / actions:

**Document Checklist**

| **Required Information:** | **Included?** | | | **Comments** |
|---|---|---|---|---|
| | **Yes** | **No** | **NA** | |
| Discharge Notification / Electronic Discharge Letter | | | | |
| TTA / TTO medication | | | | |
| DNACPR | | | | |
| Skin protocol / wound map / body map | | | | |
| **Also include if available:** | **Yes** | **No** | **NA** | **Comments** |
| PEACE Document | | | | |
| This is ME | | | | |
| Occupational Therapy Report | | | | |
| Physiotherapy Report | | | | |
| Speech & Language Therapy Report / Care Plan | | | | |
| Dietician Report | | | | |
| Mental Health Report | | | | |
| Catheter Passport | | | | |
| Other documents? | | | | |

Nursing Transfer Checklist and Letter

# HOSPITAL NURSING TRANSFER LETTER

| Glasses / Dentures / Hearing Aids available? | | | | |
|---|---|---|---|---|

**If the patient has been in hospital for > 36 hours please also complete the following 3 pages**

## INFORMATION TO SUPPLEMENT THE ABOVE DOCUMENTS

### Admission and Diagnosis

**The EDL / Discharge Summary MUST be included with this document**

Any additional information regarding admission / diagnosis that the receiving carers should be aware of (e.g. MRSA status, CDT infections, etc)?

**Is the patient/carer aware of their diagnosis/prognosis?** Yes / No / Unsure

### Medications

Date and time that regular medications/PRNs were **last administered**:……

### Supplies provided to care home

Provide details of any **new supplies or equipment** being provided (e.g. respiratory aids, oxygen, IV equipment, PEG feed, etc):

Where equipment is not going with patient, what is the **delivery date** (if known):……..

### Personal care and continence

What is the patient's current ability to **self-care**, including washing/dressing, and any necessary prompts:

What is the patient's **preference regarding washing**?

Does the patient have a **catheter**? Yes / No

Details (include reason for insertion and date due for change) OR attach catheter passport:

Does the patient have **faecal incontinence**? Yes / No

Has the patient been using **continence products** whilst in hospital? Yes / No

Details:

Have you provided a **supply of continence products**? Yes / No / Not required

### Falls and mobility

# HOSPITAL NURSING TRANSFER LETTER

Is the patient at **risk of falls**? Yes / No

If yes, please give details of the falls management plan:

Has (s)he required any **assistance or mobility aids** to walk/transfer whilst in hospital? Yes / No

If yes please specify:

**Sensory / communication**

Are there any **communication** challenges (e.g. dysphasia, language, hearing, etc)?

Details:

Does the resident use any **sensory aids** (e.g. hearing aid, glasses)? Yes/No

Details:

**Please ensure the patient has all their sensory aids with them when leaving hospital.**

**Skin and Wounds**

Nursing Transfer

# HOSPITAL NURSING TRANSFER LETTER

Have you provided a **supply of dressings or other required supplies/equipment**? Yes / No / Not required

Where relevant **a copy of the skin protocol / wound map** / body map **MUST** be included with this document**, or complete the section below:**

What is the patient's **Waterlow** score?

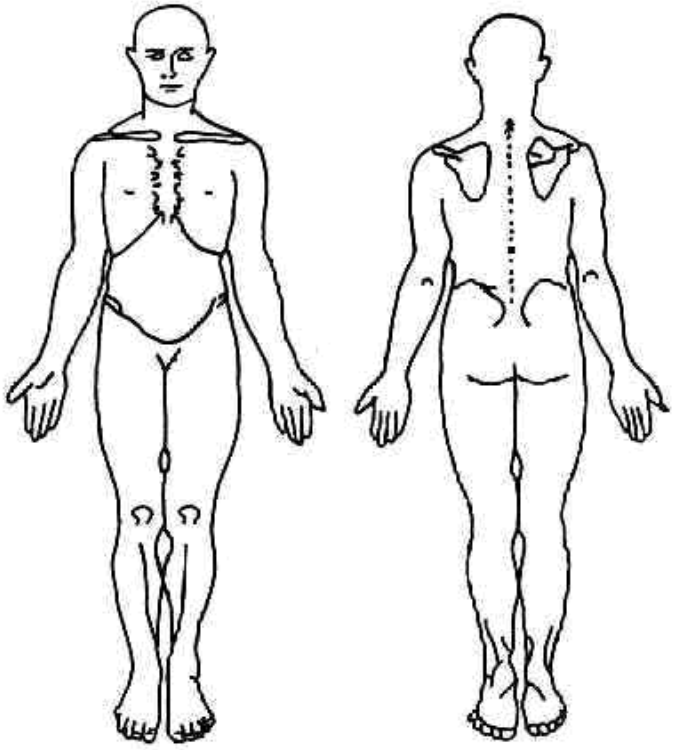
Are there any **existing pressure ulcer(s)**? Yes / No

If yes please give details, including any pressure care aids required and management plan:

Are there any **other wounds**? Yes / No

If yes please give details and management plan:

Please complete the **body map** below:



**Nutrition**

How has the patient been **eating** e.g. self-fed, needs assistance, enteral-feed?

Any food and fluid consistency recommendations e.g. thickened fluids/soft diet? Yes / No

Details:

Is the patient currently being **risk-fed**? Yes / No

Nursing

# HOSPITAL NURSING TRANSFER LETTER

Any **weight loss/gain** whilst in hospital? Yes / No / Unsure **Weight on discharge**: ……

If Yes, provide details:

**Cognition and behaviour**

Is the patient experiencing **confusion, depression, anxiety, behavioural disturbance** or other? (Including views about leaving hospital)?

Has the patient been demonstrating any **challenging behaviour** whilst in hospital (including resistance to care, wandering, violence & aggression, etc)? Yes / No

Please give details, including any suspected triggers / successful management techniques:

| | |
|---|---|
| Latest **MMSE**:<br>Latest **AMTS**:<br>Latest **MOCA**: | **CMHT** practitioner contact details (if known): |

**Any other information / summary of nursing needs:**

| | |
|---|---|
| **Form completed by:**<br>Name:<br><br>Qualification: | <br>Signature:<br><br>Date and Time: |