AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and Emergency Department Visits

Transfer Note and Intake Note

Transfer Notes and *Intake Notes* are not required, but the elements included in them must be in the nursing home's electronic medical record (EMR) to generate all components of the reports. Reports also require other elements from other data sources, including physician orders, medication records, Minimum Data Set (MDS) assessments, and nursing documentation.

Transfer Note

A transfer note is a written communication tool between the nursing home and the receiving facility—either hospital or ED. It provides a high-level summary of the reasons for transfer and what treatments (if any) were provided prior to transfer. The following data elements are suggested for capture in a consistent manner so that data can be used in reporting:

- Transfer date and time
- Transfer to location (hospital or ED)
- Reason for transfer (grouped according to symptom or condition: cardiac/circulatory/blood, respiratory symptoms, mental disorders/neurological/psychological, gastrointestinal/genitourinary, endocrine/nutritional/metabolic, wound and skin, fall-related and non-fall-related injury, musculoskeletal, other changes not specified elsewhere, or treatment not available at transferring facility)
- Treatments provided in the nursing home prior to transfer
- Providers who saw the resident within 24 hours of transfer
- Person authorizing the transfer to hospital or ED

Nursing homes will work with their EMR vendor to review and potentially modify the data elements listed in the *Transfer Note* to generate reports that meet the specific needs of the facility.

Sample Transfer Note

Resident Name:	Transfer Date: Transfer Time:	Transfer to: ☐ Emergency Department ☐ Hospital

Reason for Transfer Out of Facility

Cardiac/Circulatory/Blood

- ☐ Anemia
- ☐ Cardiac arrest
- ☐ Coagulation defect
- ☐ Chest pain/angina
- ☐ Dizzy/lightheaded
- ☐ Hypertension/uncontrolled HTN
- ☐ Hypotension
- ☐ Rule out congestive heart failure
- ☐ Rule out DVT

Respiratory

- ☐ Abnormalities of breathing
- ☐ COPD
- ☐ Cough or wheezing
- ☐ Hypoxia
- ☐ Shortness of breath
- ☐ Rule out pneumonia

Mental Disorders/Neurological/Psych

- ☐ Change in mental status (e.g. agitation, anxiety, confusion)
- ☐ Delirium
- ☐ Depression
- ☐ Dementia
- ☐ Rule out CVA
- ☐ Seizure/epilepsy/convulsion
- ☐ Decline in cognitive function and awareness
- ☐ Psychiatric (psychosis, suicidal)

Gastrointestinal/Genitourinary

- ☐ Abdominal/pelvic pain
- ☐ Diarrhea/gastroenteritis
- ☐ Dysphagia
- ☐ GI bleed
- ☐ G tube
- ☐ Hematuria
- ☐ Nausea or vomiting
- ☐ Renal failure
- ☐ Rule out kidney or urinary tract infection

Endocrine/Nutritional/Metabolic

- ☐ Dehydration
- ☐ Malnutrition
- ☐ Uncontrolled diabetes

Wound & Skin

- ☐ Cellulitis
- ☐ Edema
- ☐ Infected wound or decubitus
- ☐ Jaundice
- ☐ Rash

Fall-Related Injury

- ☐ Major injury
- ☐ Minor injury

Non-Fall-Related Injury

- ☐ Major injury
- ☐ Minor injury

Musculoskeletal

- ☐ Joint pain/joint disorder
- ☐ Weakness

Other Changes in Condition, Not Specified Elsewhere:

- ☐ Abnormal lab results
- ☐ Failure to thrive
- ☐ Fever/possible infection
- ☐ Functional decline
- ☐ Malaise/fatigue
- ☐ Potential surgical complication
- ☐ Poor intake or nutritional decline
- ☐ Weight loss

Treatment Unavailable at Transferring Facility

- ☐ Diagnostics: radiology, imaging
- ☐ IV access/fluids
- ☐ Transfusion
- ☐ Catheter insertion/reinsertion

Treatments Prior to Transfer

- ☐ Labs
- ☐ X ray
- ☐ IV fluids
- ☐ Subcutaneous fluids
- ☐ NG tube
- ☐ Oxygen
- ☐ Respiratory treatment
- ☐ Respiratory suctioning
- ☐ Medication: IV
- ☐ Medications: IM or SQ
- ☐ Medications: PO

Seen by (Within 24 Hours of Transfer)

- ☐ Primary Physician
- ☐ Covering Physician
- ☐ Consulting Physician
- ☐ Nurse Practitioner or PA
- ☐ Respiratory Therapist
- ☐ Other

- ☐ Transfer requested by resident/family

Authorized by:

- ☐ Resident's Primary Physician/Name_____
- ☐ Other Provider/Name_____
- ☐ Medical Director/Name_____
- ☐ Medicare Managed Care Organization
- ☐ Outside Clinic or Service

Intake Note

The *Intake Note* is written to capture information in a standardized way about the hospital or ED visit upon return to the nursing home, to use it in reporting, and to facilitate improved monitoring and management of resident care. The *Intake Note* is a mechanism to capture more details about the resident's care across settings than is currently available. The *Intake Note* is completed for each resident returning from a hospital admission, ED visit, or observation visit.

- Admit date and time
- Admit to unit (long-term care, subacute or rehab)
- Intake type (ED visit, observation stay, or hospital admission)
- Hospital length of stay or hospital admission date
- Treatment received in the ED, if returning from ED
- Discharge diagnosis from hospital (principal diagnosis and secondary diagnoses)
- Surgical procedures received in the hospital, if applicable

Sample Intake Note

Resident Name:	Admit Date: Admit Time:	Admit to: ☐ Long Term Care ☐ Subacute or Rehab

Intake Type:

- ☐ ED Visit
- ☐ Observation Stay
- ☐ Hospital Admit (Enter one of the following)
  - ☐ Hospital Admission Date OR
  - ☐ Hospital LOS

If admitted from one of the following, do not complete this form:

- ☐ Long-Term Care Facility
- ☐ Assisted Living
- ☐ Home

Treatments Received in the ED/HOSP

Catheter Insertion/Reinsertion

- ☐ Foley
- ☐ Ostomy
- ☐ PEG
- ☐ Suprapubic

Diagnostics

- ☐ EKG
- ☐ CT scan
- ☐ Doppler studies
- ☐ MRI
- ☐ Ultrasound
- ☐ X rays
- ☐ Other

IV Access/Insertion and Fluids

- ☐ PICC
- ☐ Central
- ☐ Peripheral
- ☐ IV fluids

Labs Obtained

- ☐ Electrolytes
- ☐ Cardiac workup
- ☐ CBC
- ☐ Blood cultures
- ☐ Other

Medications

- ☐ Oral
- ☐ IM or IV
- ☐ Subcutaneous

- ☐ Observation only

Respiratory

- ☐ Oxygen therapy
- ☐ Respiratory treatment
- ☐ Suctioning

- ☐ Transfusion
- ☐ Other _____

Surgical Procedure During Hospital Stay?

- ☐ Abdominal
- ☐ Cardiac
- ☐ Hip fracture
- ☐ Other fracture
- ☐ Joint replacement
- ☐ Other major surgery, not listed above

ED Discharge/Hospital Discharge Diagnoses: Primary & Secondary
(*Indicate principal or secondary if more than one hospital discharge diagnosis.*)

	Principal	Secondary
☐ Anemia	☐	☐
☐ Angina	☐	☐
☐ Asthma	☐	☐
☐ Atrial fibrillation	☐	☐
☐ Acute MI	☐	☐
☐ Cellulitis	☐	☐
☐ CHF	☐	☐
☐ Circulatory problems	☐	☐
☐ COPD	☐	☐
☐ CVA	☐	☐
☐ Dehydration	☐	☐
☐ Dementia	☐	☐
☐ Depression	☐	☐
☐ Diabetes	☐	☐
☐ Dysrhythmias	☐	☐
☐ Electrolyte imbalance	☐	☐
☐ Fever	☐	☐
☐ Fall - injury	☐	☐
☐ Gastroenteritis	☐	☐
☐ Genitourinary problems	☐	☐
☐ GI bleed	☐	☐
☐ Hypotension	☐	☐
☐ Hypertension	☐	☐
☐ Hypoglycemia	☐	☐
☐ Hyperglycemia	☐	☐
☐ Kidney infection	☐	☐
☐ Medication reaction	☐	☐
☐ Mental status change	☐	☐
☐ Mental disorder/psychosis	☐	☐
☐ Neoplasm	☐	☐
☐ Pneumonia	☐	☐
☐ Pressure ulcer	☐	☐
☐ Peripheral vascular disease	☐	☐
☐ Respiratory, other nonpneumonia	☐	☐
☐ Renal disease	☐	☐
☐ Seizure	☐	☐
☐ Sepsis/urosepsis	☐	☐
☐ Surgical complications or infection	☐	☐
☐ Syncope	☐	☐
☐ Urinary tract infection	☐	☐
☐ Other _____	☐	☐