

**PATIENT TRANSFER SUMMARY
FOR ADULT RESIDENTIAL CARE HOMES**

Name _____ Marital status: **S** **M** **W** **D** **S.S.#** _____

DOB _____ Sex _____ Racial Extraction _____ Religious Pref. _____

Transferred to: _____ Date: _____ Manager _____ Ph.# _____

Reasons for transfer _____

Name of responsible family or agency notified: _____

Any history of violent, destructive behaviour to person or property, or wandering behaviour?

I. Physician's orders and recommendations. (Attached copy of most current physical exam, T.B. clearance, and Physician's orders, including diet medications and level of care).

II. Type of care needed (Describe plan of care):

A. Behaviour management: _____

B. Sleeping habits: _____

C. Elimination pattern: _____

D. Eating habits: _____

E. Self-care skills: _____

F. Allergies: _____

III. Activity Therapy Programs (O.T., P.T., Recreation, Work Training):

A. Indoor activities: _____

B. Outdoor activities: _____

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IV. Social Summary:

A. Permanent address: _____

Nearest relative to call:

Name: _____ Relationship: _____ Phone: _____

Address: _____

Legal Guardian: _____ Phone #: _____

Power of Attorney: _____ Phone #: _____

Family interest and support: _____

V. Medical Summary:

Medical follow-up due: _____ Psychiatric follow-up due: _____

Physician: _____ Psychiatrist: _____

Dentist: _____ Dental follow-up due: _____

Medical Plan: _____ Ins. #: _____

Living Will signed and available? _____

Signature: _____ Date: _____

Name of ARCH: _____