Transfer Checklist and Feedback

Sending Facility:_____ Receiving Facility: _____

Person & Phone Number of Receiving Facility Requesting Info: _____

Patient's Name_____ Date: __/__/__ Time: _ _:_ _ (military)

☐ **All** information necessary to treat the patient was **received**.
☐ The following information necessary to treat the patient was **not received or was incomplete**:

☐ Face sheet with demographic and insurance information	☐ Discharge Summary or discharge paperwork
☐ Medication list missing ☐ Medication list incomplete, missing: _____	☐ Treatment orders (wound care, nursing care, OT/PT/Speech therapy, lab orders)
☐ Reason for transfer	☐ H & P or Medical History
☐ Face to Face	☐ Verbal Report or Nurse to Nurse Report
☐ Advance Directives and/or Code Status	☐ Inadequate supplies for care
☐ Safety Concerns/Special Treatments:	☐ Other:

Please fax form **within 1 business day** to:
1. Contact person listed below *and*
2. NHCQF Fax

Form received on: ____/____/____ To be completed and resent **ONLY** if all information was not received.
RESPONSE: The following is now in place to prevent these deficiencies from occurring with future referrals:

_____

_____

_____

_____

_____

_____

_____

Person completing form: _____

*Please fax form **within 5 days** to Contact Person at Receiving Facility **and** NHCQF Contact*

This material was prepared by Northeast Health Care Quality Foundation (NHCQF), the Medicare Quality Improvement Organization (QIO) for Maine, New Hampshire and Vermont, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 0812-1152-C.8.N