UPMC LIFE CHANGING MEDICINE

HAMOT

Outpatient Service Communication Form for Persons from Residential Living Providers

IMPRINT PATIENT IDENTIFICATION HERE

Patient Name_____ DOB _____/_____/_____

Ordering Physician _____Phone (_____) _____-_____

Sending Facility _____Phone (_____) _____-_____

Date of Transfer _____/_____/_____ Time of Transfer _____:_____ Transporting Company_____

Scheduled exam/procedure _____

Reason _____

Allergies _____

Current Vital Signs Height _____ Weight _____ Temp _____

Pulse _____ Resp _____ BP _____/_____ BG _____

Past Medical History _____

_____

PLEASE SEND A RECENT PHYSICIAN H & P WITH PATIENT AT TIME OF TRANSFER

Mediations given _____

PLEASE SEND A CURRENT MEDICATION LIST WITH PATIENT AT TIME OF TRANSFER

Ambulatory Status

___Independent
___WC / Cane / Walker
___Bed Rest
___Other _____

Neuro

___A & O x 3
___Confused
___Lethargic
___Unresponsive **

GI / GU

___Colostomy/ Ileostomy
___Incontinent
___G / Peg Tube / J Tube
___Foley

Blood transfusion patients must have UPMC Hamot Blood Transfusion orderset completed and a signed blood transfusion consent form at time of transfer.

**ATTN if > 6LNC O2, Vent, Intubated, Airborne or TB isolation - these patients do not meet outpatient criteria and must go to Inpt/ICU.

**If patient unresponsive, contact outpatient charge nurse beeper 814-877-0752

Communication Barriers

___None
___Glasses ___Blind
___Deaf ____Hard of Hearing/Hearing Aids
___Non-English Speaking:
Language_____
Interpreter_____

Respiratory / Cardiac

___O2 liters_____ **Via_____
___Trach / Intubated**
___SOB / Cough
___Ekg (rhythm)_____
___Pacemaker / ICD

Wound / Skin / IV

___Drains / Wound Vac
Location & Type _____
___Pressure Ulcer / Sore
Location & Size_____
___IV / Central Line
Location & Size_____

Isolation (√ all that apply)

___None
___Contact - MRSA / c.Diff
___MDRO - VRE / c. Diff
___Droplet
___Airborne (TB) **

Diet

___Regular
___Tube Feeding Rate
Formula & Rate _____
___NPO Time _____:_____
___Other_____

Labs (Value & Date)

___BUN _____ _____/_____/_____
___Creatinine _____ _____/_____/_____
___PT / INR _____ _____/_____/_____
___Glucose _____ _____/_____/_____
___Hgb_____ _____/_____/_____
___Hct_____ _____/_____/_____
___Plt_____ _____/_____/_____

Staff Completing Form_____Date_____/_____/_____Time_____:_____

Emergency Contact/Family ____ _____Phone(_____)_____-_____