Date: [Date of Transfer]

GERIATRIC TRANSFER / DISCHARGE SUMMARY

PATIENT DETAILS:
Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Gender: [Gender]

FACILITY INFORMATION:
Transferring Facility: [Current Facility Name]
Receiving Facility: [Destination Facility Name]
Reason for Transfer: [e.g., Level of care change, Long-term placement]

MEDICAL OVERVIEW:
Primary Diagnosis: [Main Medical Condition]
Secondary Diagnoses: [Comorbidities, e.g., Dementia, HTN, Diabetes]
Allergies: [List Allergies or NKA]

FUNCTIONAL & COGNITIVE STATUS:
Cognitive Status: [e.g., Alert/Oriented, Advanced Dementia, Sun-downing]
Mobility: [e.g., Bedbound, Assist of 1, Independent with Walker]
ADLs: [Level of assistance required for eating, bathing, toileting]
Diet: [e.g., Regular, Pureed, Thickened Liquids]

MEDICATION SUMMARY:
[List of current medications, dosages, and schedules or "See attached MAR"]

NURSING & CARE NEEDS:
Skin Integrity: [e.g., Intact, Pressure Ulcer Stage/Location]
Incontinence: [Bowel/Bladder status]
Medical Equipment: [e.g., Oxygen 2L, CPAP, Foley Catheter, Ostomy]

SOCIAL & LEGAL:
Code Status: [DNR/DNI or Full Code]
Power of Attorney (POA): [Name and Contact Number]
Next of Kin: [Name and Contact Number]

TRANSFERRING PROVIDER SIGNATURE:
Name: ____________________________
Title: _____________________________
Phone: ____________________________