COORDINATION of CLIENT TRANSFER CHECKLIST

Client Name: _____Phone #: _____

Client Home Address:_____ D.O.B. _____

Primary Language:_____ Secondary Language:_____

Caregiver Name_____ Caregiver's Phone # _____

Primary Physician_____ Phone # _____

Specialist(s) _____ Phone #.: _____

Psychiatrist/Mental Health Provider_____Phone:#:_____

Insurance Information: _____

Diagnosis;_____

Medications: (Name, Dosage, Frequency, Date of Refill)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

Medication Allergies

1 _____ 3 _____

Consent for Referral & Release of Information form signed: _____Yes _____No ____Refused (Provide Reason)

_____

Outside Resource/Other Health Care Provider Receiving Client:

Name: _____Phone #: _____

Contacts with Client's Primary Care Physician:

1. Date: _____ Comments:

_____

_____

2. Date: _____ Comments:

_____

_____

Required Follow-Up: ____Yes ____ No ____ N/A Comments:

_____

Contact with Client's Medical Specialist: ____N/A

1. Date: _____ Comments:

_____

_____

2. Date: _____ Comments:

_____

_____

Required Follow-Up: ____Yes ____ No ____ N/A Comments:

_____

Contact with Client's Psychiatrist/Mental Health Provider: ____ N/A

1. Date: _____ Comments:

_____

2. Date: _____ Comments:

_____

Required Follow-Up: ____Yes ____ No ____ N/A Comments:

_____

_____

Contact with Outside Resource/Other Health Care Providers

:

1. Date: _____ Comments:

_____

_____

_____

2. Date: _____ Comments:

_____

_____

Required Follow-Up: ____Yes ____ No ____ N/A Comments:

_____

_____

3. Date: _____ Comments:

_____

_____

_____

ACTIVITY	RESPONSIBILITY	N/A	COMPLETED		
			YES	NO	DATE
Assessment Conducted					
Ambulatory Aids &/or Special Equipment used &/or needed by client identified &/or recommended.					
Significant health and safety factors discussed with client/client's representative and documented in the record.					
Care Plan Developed with Client/Family Input					
Client/Client's Representative understand information & have a copy of Care Plan.					
Client /Family choose to contact Outside Resource/Other Health Care Provider personally. Contact details provided.					
Client/Family request Agency to contact Outside Resource/Other Health Care Provider.					
Consent for Referral & Release of Information signed by Client					
If a consent to authorize the release of information is declined, this refusal is documented.					
Discharge/Transfer Client Notification completed & given to Client.					
Copy of Assessment sent to Client's Primary Care Physician					
Copy of Assessment sent to Client's Specialist					
Copy of Assessment sent to Outside Resource/Other Health Care Provider/ Other Health Care Provider.					
Client's significant health and safety factors shared with Outside Resource/Other Health Care Provider/Other Health Care Provider					
Outside Resource/Other Health Care Provider/ Other Health Care Provider responded to Agency's initial contact.					
Case Manager for Agency established.					
Case Manager for Outside Resource/Other Health Care Provider/Other Health Care Provider established.					
Participants of Coordination Team established.					
Responsibilities of Case Manager for Agency defined.					
Responsibilities of Case Manager for Outside Resource/Other Health Care Provider/Other Health Care Provider defined.					
Responsibilities for other Coordination Team Participants defined.					
Follow-up with Client's Primary Care Physician & documented, as indicated.					
Follow-up with Client's Specialist & documented, as indicated					
Follow-up with Client's Other Health Care Professional & documented, as indicated					
Date for transfer established.					
Procedures for Transfer established.					
Medicare contacted, if client is a beneficiary.					

ACTIVITY	RESPONSIBILITY	N/A	COMPLETED		
			YES	NO	DATE
Third Party Payors notified of transfer as required.					
All transition services and care (medications, equipment hospice) coordinated and documented					
Discharge/Transfer Summary completed.					
Name, phone, and address at the given to Outside Resource/Other Health Care Provider at time of intake					
Obtain consent from Client/Client's Representative to exchange information with the referring Agency					
Separate informed consent to release information obtained from client/client's representative by Outside Resource/other Health Care Provider.					
Client data & transition information documented in client's record.					

Comment, if indicated;

1. Reason Client refused to sign *Consent for Referral & Release of Information*

_____

_____

2. Reason Client refused to sign consent for Outside Resource/Other Health Care Provider exchange information with the referring Agency

_____

_____

3. Additional Comments (if any)

_____

_____

_____

_____

_____

_____

Name & Position of Agency Representative: _____

Agency Representative: Signature: _____