

## *INTERACT<sup>II</sup>* **Instructions for Resident Transfer Form**



### **Purpose:**

This form is completed on every resident who is transferred to the emergency department for evaluation and treatment. The purpose is to provide information about the resident's change in condition, a short narrative about what happened and the reason why the resident is being transferred (e.g., "short of breath, no improvement after 3 days of antibiotics," "fell and now has change in mental status.")

Consistent use of this tool will help your nursing home:

- Provide essential information to emergency department staff that will lead to the most appropriate evaluation of your residents
- Insure the safe handoff of your residents to the emergency department

### **When to complete:**

Page 1 of this form should always be completed and sent in the transfer envelope with the resident, since it contains essential information that the emergency department staff may need to make decisions about the resident. Page 2 also contains important information, but may be faxed to the hospital after the resident has been transferred, in the case of a 911 transfer or resident in unstable condition, or it may be sent along with the page 1.

### **Who to involve:**

Generally, the nurse has discussed the transfer with a physician/PA/NP (primary or covering) prior to transfer. It is helpful to include any clinical information from the provider in the Reason for Transfer section. The name of the provider, and how to reach him or her should always be included. The nurse completing the form should sign it, even if another nurse (e.g., a supervisor) is listed as the person to contact for questions about the resident. The staff nurse might complete the form; she should then sign it. The supervisor might be the right person to contact for questions later, if the staff nurse is going home. A Provider to Provider (physician/NP/PA) telephone call is strongly recommended, so that the medical details can be shared among the nursing home and emergency department staff. A nurse to nurse telephone call is also strongly recommended, so that specific nursing issues and changes in resident status can be communicated. Complete the section of the form that asks who made this call and who at the ED received the call. If a resident returns to the nursing home after an emergency department evaluation, a telephone call from the ED nurse to the nursing home nurse is strongly encouraged.

### **Helpful Hints:**

- **Complete all sections of the tool:** The tool is designed to help guide you write a brief but comprehensive summary of the resident's situation.
- **Do not rewrite information that exists elsewhere that is being sent with the resident.** If the SBAR form has been completed, write "see SBAR" for sections with similar information

## *INTERACT<sup>II</sup>* **Instructions for Acute Care Transfer Envelope**



### **Purpose:**

This checklist (on the outside of the transfer envelope) is completed on every resident who is transferred to the emergency department for evaluation and treatment. The purpose is to provide a single envelope with all the necessary forms inside that the emergency department staff need to evaluate and manage the resident.

Consistent use of this tool will help your nursing home:

- Provide essential information in one, easily recognizable place, to emergency department staff that will lead to the most appropriate evaluation of your residents
- Insure the safe handoff of your residents to the emergency department

### **When to complete:**

Use the checklist to systematically determine that all of the necessary paperwork has been sent with the resident. As each document is placed in the envelope, check off the appropriate box on the outside to indicate that the document has been included.

### **Who to involve:**

The person completing the checklist should sign it and request a signature from the EMS or ambulance personnel who accept the envelope, indicating that all required documents have been sent.