



INTERACT^{II}

Interventions to Reduce Acute Care Transfers

Acute Care Transfer Log

Name of Your Facility: _____

Month: _____

Resident Room Number	ED visit only (Not Admitted)	Admitted	QI Review Tool Completed	QI Review Tool Faxed/Emailed

Use additional pages if necessary for the month

Person completing this form: _____

Date: ___/___/___