



Hamilton

**Residential Care Facility
FORM 2 – TRANSFER SHEET**

RESIDENTIAL CARE FACILITY INFORMATION

Name:

Address:

Telephone:

TENANT INFORMATION

Name:

Health Card #:

Family Dr:

Phone:

Specialist:

Phone:

BRIEF MEDICAL HISTORY

NEXT OF KIN

Name:

Relationship:

Address:

Phone:

COMMUNITY WORKER

Name:

Agency:

Phone:

TRANSFER INFORMATION

Transfer TO:

Transfer FROM:

Date & Time:

Date & Time:

Reason for Transfer:

Physical Functioning: Independent Requires Assistance

Specify:

Diet:

MENTAL HEALTH

Oriented to person, place, time: YES NO, specify:

Confusion: Never Sometimes Frequently

Aggression/Agitation: Never Sometimes Frequently

TB SKIN TEST OR CHEST X-RAY

A.	Skin Test Date:	1.	2.
	Skin Test Results:	1.	2.
B.	Chest X-Ray Date:	1.	2.
	Chest X-Ray Result:	1.	2.

ADDITIONAL INFORMATION (Pertinent to follow-up care of tenant eg. medication changes, lab tests, diagnoses, follow-up plan, etc)

Medication List Attached: YES NO

ALLERGIES:

Signature of Operator/Manager:

Date:

DD / MM / YYYY

NOTES:

1. Sending facility to keep original form.
2. Receiving facility to keep copy of form.