**A. PATIENT INFORMATION**

*Gender: [ ] Male  [ ] Female
*Hispanic Ethnicity: [ ] Yes  [ ] No
*Race: [ ] White  [ ] Black  [ ] Other:  
*Language: [ ] English  [ ] Other:

**B. SIGHT**

[ ] Normal  [ ] Impaired  [ ] Deaf  [ ] Normal  [ ] Impaired
[ ] Blind  [ ] Hearing Aid  

**C. DECISION MAKING CAPACITY (PATIENT)**

[ ] Capable to make healthcare decisions  [ ] Requires a surrogate

**D. EMERGENCY CONTACT**

Name: ___________________________  Name: ___________________________

Phone: ___________________________  Phone: ___________________________

**E. MEDICAL CONDITION**

*Primary diagnosis:
*Other diagnoses:

If Hospitalized:
Primary diagnosis at discharge:
Reason for transfer:
Surgical procedures performed:

**F. INFECTION CONTROL ISSUES**

PPD Status: [ ] Positive  [ ] Negative  [ ] Not known
Screening date: ___________________________
Associated Infections/resistant organisms:
[ ] MRSA  Site: ___________________________
[ ] VRE  Site: ___________________________
[ ] ESBL  Site: ___________________________
[ ] MDRO  Site: ___________________________
[ ] C-Diff  Site: ___________________________
[ ] Other: Site: ___________________________
Isolation Precautions: [ ] None  
[ ] Contact  [ ] Droplet  [ ] Airborne

**G. PATIENT RISK ALERTS**

[ ] None Known  [ ] Harm to self  [ ] Difficulty swallowing
[ ] Elopement  [ ] Harm to others  [ ] Seizures
[ ] Pressure Ulcers  [ ] Falls  [ ] Other: ___________________________

**RESTRAINTS:** [ ] Yes  [ ] No
Types:

Reasons for use:

**ALLERGIES:** [ ] None Known  [ ] Yes, List below:

Latex Allergy: [ ] Yes  [ ] No  Dye Allergy/Reaction: [ ] Yes  [ ] No

**H. ADVANCE CARE PLANNING**

Please ATTACH any relevant documentation:

- Advance Directive: [ ] Yes  [ ] No
- Living Will: [ ] Yes  [ ] No
- DO NOT Resuscitate (DNR): [ ] Yes  [ ] No
- DO NOT Intubate: [ ] Yes  [ ] No
- DO NOT Hospitalize: [ ] Yes  [ ] No
- No Artificial Feeding: [ ] Yes  [ ] No
- Hospice: [ ] Yes  [ ] No

**I. TRANSFERRED FROM**

Facility Name: ___________________________
Date: ___________________________  Unit: ___________________________
Phone: ___________________________  Fax: ___________________________
Discharge Nurse: ___________________________
Admit Date: ___________________________  Discharge Date: ___________________________
Admit Time: ___________________________  Discharge Time: ___________________________
**J. TRANSFERRED TO**

Facility Name: ___________________________
Address 1: ___________________________
Address 2: ___________________________
Phone: ___________________________  Fax: ___________________________

**K. PHYSICIAN CONTACTS**

Primary Care Name: ___________________________
Phone: ___________________________
Hospitalist Name: ___________________________
Phone: ___________________________

**L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION**

Medication due near time of transfer / list last time administered
Script sent for controlled substances (attached): [ ] Yes  [ ] No

[ ] Anticoagulants  Date: ___________________________  Time: ___________________________
[ ] Antibiotics  Date: ___________________________  Time: ___________________________
[ ] Insulin  Date: ___________________________  Time: ___________________________
[ ] Other: Date: ___________________________  Time: ___________________________

Has CHF diagnosis: [ ] Yes  [ ] No
If yes; new/worsened CHF present on admission?
[ ] Yes  [ ] No
Last echocardiogram: Date: ___________________________  LVEF %

On a proton pump inhibitor? [ ] Yes  [ ] No
If yes, was it for: [ ] In-hospital prophylaxis and can be discontinued
[ ] Specific diagnosis:

Any critical lab or diagnostic test pending at the time of discharge? [ ] Yes  [ ] No
If yes, please list:

**M. PAIN ASSESSMENT**

Pain Level (between 0 - 10): ___________________________
Last administered: Date: ___________________________  Time: ___________________________

**N. FOLLOWING REPORTS ATTACHED**

[ ] Physicians Orders  [ ] Treatment Orders
[ ] Discharge Summary  [ ] Includes Wound Care
[ ] Medication Reconciliation  [ ] Lab reports
[ ] Discharge Medication List  [ ] X-ray  [ ] EKG
[ ] PASRR Forms  [ ] CT Scan  [ ] MRI
[ ] Social and Behavioral History  [ ] History & Physical

*ALL MEDICATIONS: (MUST ATTACH LIST)*

**Data required for Medicaid**
**Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form**

**O. Vital Signs**
- **Date:**
- **Time Taken:** AM □ PM □
- **HT:** FEET INCHES WT:
- **Temp:**
- **BP:** /
- **HR:**
- **RR:**
- **SpO2:**

**P. Patient Health Status**
- **Bladder:** Continent □ Incontinent □
- **Ostomy:** Continent □ Incontinent □
- **Catheter Type:**
- **Date Inserted:**
- **Foley Catheter:** Yes □ No □
- **If yes, date inserted:**

**Indications for use:**
- Urinary retention due to:
- Monitoring intake and output
- Skin Condition:
- Other:

**Attempt to remove catheter made in hospital?**
- Yes □ No □
- **Date Removed:**

**Bowel:**
- Continent □ Incontinent □
- **Ostomy**

**Date of Last BM:**

**Immunization status:**
- Influenza: Yes □ No □
- Date:
- Pneumococcal: Yes □ No □
- Date:

**Q. Nutrition / Hydration**
- **Dietary Instructions:**
  - Tube Feeding: G-tube □ J-tube □ PEG
  - **Insertion Date:**
  - Supplements (type): TPN □ Other Supplements:
- Eating: Self □ Assistance □ Difficulty Swallowing

**R. Treatments and Frequency**
- **PT - Frequency:**
- **Speech - Frequency:**
- **Dialysis - Frequency:**

**S. Physical Function**
- **Ambulation:**
  - Not ambulatory
  - Ambulates independently
  - Ambulates with assistance
  - Ambulates with assistive device
- **Transfer:**
  - Self
  - Assistance
  - 1 Assistant
  - 2 Assistants
- **Devices:**
  - Wheelchair (type):
  - Appliances:
  - Prosthesis:
  - Lifting Device:

**Weight-bearing:**
- Left:
  - Full □ Partial □ None
- Right:
  - Full □ Partial □ None

**U. Mental / Cognitive Status at Transfer**
- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, and cannot follow simple instructions
- Not Alert

**V. Treatment Devices**
- **Heparin Lock - Date changed:**
- **IV / PICC / Portacath Access - Date inserted:**
  - **Type:**
- **Internal Cardiac Defibrillator** □ Pacemaker
- **Wound Vac**
- **Other:**
- Respiratory - Delivery Device:
  - CPAP □ BiPAP
  - Nebulizer □ Other:
  - **Nasal Cannula**
  - **Mask:** Type
  - Oxygen - liters: ___% □ PRN □ Continuous
  - **Trach Size:** Type:

**W. Personal Items**
- Artificial Eye □ Prosthetic □ Walker
- Contacts □ Cane □ Other
- Eyeglasses □ Crutches
- Dentures □ Hearing Aids
- **U □ L □ Partial □ L □ R**

**X. Comments (Optional)**

**Signature:**

**Printed Name:**

**Y. Physician Certification**
- *I certify the individual requires nursing facility (NF) services.*
- *The individual received care for this condition during hospitalization.*
- *I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.*

**Rehab Potential (check one):**
- Good □ Fair □ Poor

**Effective date of medical condition:**
- **Physician/ARNP/PA License #:**
- **Physician/ARNP/PA Signature:**
- **Date:**
- **Printed Physician/ARNP/PA Name & Title:**
- **Phone Number:**
- **Date:**

**Z. Person Completing Form**

**Name:**

**Phone Number:**

**Date:**

AHCA Form 5000-3008, (JUN 2016) incorporated by reference in Rule 59G-1.045, F.A.C.

*Sections required for Medicaid*