



NORTH SOMERSET & WESTON AREA HEALTH TRUST

INTEGRATED TRANSFER OF CARE LETTER

The objective of the shared transfer of care form is to enable safe management of a patient either into an acute care setting or returning to the community. (Please circle where necessary).

North Somerset & Weston Area Health trust Integrated Transfer of Care letter

Patient Name:
pt ID

Date of Birth:

Date of Transfer:

Transferring to:

Significant Carers/NOK Name and contact number:

Ward/Home address _____

Transfer **From** contact number _____

Consultant or GP: _____

Reason for Admission to Hospital/need for community services _____

Is the patient cognitively impaired Yes / No (please specify) _____

Hospital passport / traffic light form with patient Yes / No

Capacity to understand care needs Full/ Variable/ None	Cardiopulmonary resuscitation status For / Not For (circle) Date of decision:
Patient at risk of Pressure Ulcer Yes / No Pressure ulcer present Yes / No (If yes detail site etc on Tissue Viability form)	Mobility aids with patient Yes/ No specify: Mobility Status: Independent / requires assistance / dependant
Communication aids with patient Glasses / hearing aid / dentures / books.	Bed rails used Yes / No Night Sedation Taken Yes No
Continence needs: (include when catheter was last changed if applicable)	Nutritional status: full diet taken/ poor appetite/ Nil by Mouth/ PEG
Special diet required?	Dietary Supplements with patient Yes/No

North Somerset & Weston Area Health trust Integrated Transfer of Care letter

Swallowing difficulties Yes / No	Involvement of SALT/Dietician: Yes / No
Weight on transfer: kg	Blood glucose on transfer if applicable
Patients own Medications returned with patient: Yes/ No	Valuables with / returned to patient Yes/No Detail:
Any outpatients appointments whilst patient is in hospital Yes / No	Detail:
Does the patient have an end of life plan in place	Yes / No
Does the patient have a pressure ulcer Prevention Plan	Yes / No
Does the patient have a current Warfarin INR level and appointment	Yes / No (If yes give details)
Supplementary Information Please detail any further care needs: Oxygen Therapy, Special Diets, Power of Attorney, etc.	
Additional comments/requests for receiving carers/Hospital staff (include any outstanding anxieties expressed by patient.	
Does patient have their toiletries etc with them Yes/ No	Does patient have clean clothes to transfer home Yes/ No
Does patient have safe well fitting footwear for mobilisation Yes /No	Has the patients soiled clothing been bagged appropriately for direct use in washing machine Yes/ No
Dosset Box required for discharge Yes / No	Infection control issues Yes / No (If yes complete Infection control transfer form)

Name, Signature and status of staff transferring _____

Date Form completed _____

Please contact the ward/carers/Care home should you have concerns regarding the transfer.

