RACH staff to complete

RACH name: ______________________

Wing/Unit: ______________________

Nurse: ______________________

Attach sticker here

Last name: ______________________

First name: ______________________

Date of birth: ______________________

Preferred name: ______________________

CARE ALERTS

- ☐ **Allergies:** ______________________
- ☐ **Behaviour:** ______________________
- ☐ **Communication:** ______________________
- ☐ **Infectious:** ______________________
- ☐ **Implanted device:** ______________________
- ☐ **Other:** ______________________
- ☐ Interpreter Required. **Language Spoken:** ______________________
- ☐ **Diet:** ☐ Nil by mouth ______________________
- ☐ **Cognitive impairment:** ☐ Mild ☐ Moderate ☐ Severe
- ☐ **Mobility:** ☐ Independent ☐ Supervised ☐ 1 x Assist ☐ 2 x Assist ☐ Stick ☐ Walker ☐ Wheelchair ☐ Rollator

Checklist for transfer

☐ **Information available on My Health Record**

Enclosed in the envelope is:

- ☐ Reason for transfer
- ☐ Usual functionality and observations
- ☐ Copy of current signing sheet including PRN page
- ☐ 24 hours of medication sent with patient
- ☐ GP health summary / Medical Assessment
- ☐ Other information e.g. pathology, x-rays
- ☐ Enduring power of attorney (EPOA), Adult guardian documentation *(circle as appropriate)*
- ☐ Advance Health Directive (AHD), Statement of Choices (SOC), End of Life Plan (EOL), Advance Resuscitation Plan (ARP) *(circle as appropriate)*
  - ☐ Does not have advance care plan (ACP)

Contacts

GP

☐ Contact details enclosed

Aware of transfer? YES / NO

Time contacted: ______________________

Hospital / RADAR

Hospital: ______________________

Name of person spoken with: ______________________

RADAR clinical pathway used? YES / NO

Aware of transfer? YES / NO

Time contacted: ______________________

Best contact

☐ Contact details enclosed

Name: ______________________

Relationship: ______________________

Aware of transfer? YES / NO

Time contacted: ______________________

Personal belongings

- ☐ **Dentures** ☐ Upper ☐ Lower ☐ Full
- ☐ **Glasses**
- ☐ **Hearing aid** ☐ Left ☐ Right
- ☐ **Mobility aids:** ______________________
- ☐ **Bag:** ______________________
- ☐ **Other:** ______________________

This person is a resident of an aged care home

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Hospital staff to complete

Hospital: ____________________
Unit: ____________________
Direct phone: ____________________

Attach sticker here

Last name: ____________________
First name: ____________________
Date of birth: ____________________
Preferred name: ____________________

This person is a resident of an aged care home

Swab/s completed prior to discharge: ____________________
Result: ☐ **Pos** ☐ **Neg** ☐ **TBC**

☐ **Information added to My Health Record**

Notifications

GP

Aware of transfer? YES / NO

☐ Electronic discharge summary
☐ Phone ☐ Email
☐ Fax ☐ Mail

Time contacted: ____________________
Name of person spoken with: ____________________

RACH

Aware of transfer? YES / NO

Time contacted: ____________________
Name of person spoken with: ____________________

Best contact

Aware of transfer? YES / NO

Time contacted: ____________________
Name of person spoken with: ____________________

Discharge checklist

Medical

☐ Medical discharge summary
☐ EDDMAR

Pharmacy

☐ Discharge medication summary
☐ IMAR
☐ Medication dispensed

Nursing

☐ Nursing summary
☐ Allied Health / RADAR summary
☐ Medication administration record
☐ Confirmed pharmacy and medical discharge enclosed
☐ Pressure injury check complete
☐ Wound care
☐ IVC removed

Care planning

Care planning documents developed and enclosed:

☐ Advance Health Directive
☐ Statement of Choices
☐ Adult Guardian Order
☐ Advance Resuscitation Plan
☐ Advance Care Plan
☐ Other: ____________________

Personal belongings

☐ **Dentures** ☐ Upper ☐ Lower ☐ Full
☐ **Glasses**
☐ **Hearing aid** ☐ Left ☐ Right
☐ **Patient's own medication**

☐ **Mobility aids:** ____________________
☐ **Bag:** ____________________
☐ **Other:** ____________________

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