King's College Hospital NHS
NHS Foundation Trust

Transfer Form: Emergency Department to Care Homes

Resident/Patient Name:		**Date of Birth:**	
NHS Number:		**Hospital Number:**	
Reason(s) for A&E attendance:			
Date of attendance:		**Date & time of discharge:**	
Name of care home discharged to:			

Documents received from LAS (please circle): Transfer Letter MAR chart Body MAP DNACPR PEACE

Diagnosis on discharge:		**TTA Sent?**	

Please indicate in what area(s) of ED the patient was seen (please tick where appropriate):

CDU		**Minors**		**Majors**		**Resus**	

What investigations took place?	
What was the outcome?	

What intervention (if any) took place while the patient was in ED?

	Name/type	**Dosage**
Medication		
Fluids		

	Yes	**No**	**Further Information**
Dressings			Type:
Pressure areas			Grade:
Sutures			Amount/site:

Catheter Care	**Yes**	**No**	**If not, was a catheter inserted in ED?**	**If so, what type?**
Did the patient have a catheter prior to ED presentation?			**Yes** ☐ **No** ☐ **Catheter Passport** ☐	
Trial Without Catheter (TWOC) Appointment:			**Outpatient Dept Kings**	**Care Home**

Has a copy of the discharge summary been sent to the GP? YES NO

If the patient has a DNACPR, has a copy of the form been discharged with the patient?
YES NO

What follow up is planned? Referrals/actions by care home?

Was an advisory leaflet given to the patient on discharge (please circle): Yes No

SIGNATURE: _____ **DESIGNATION:** _____ **DATE:**_____

Please contact Nurse in Charge on: 020 3299 1880 (Fax: 020 3299 3911) if you have any queries.

Once completed, a copy of this form must be given to the patient on transfer from the Emergency Department. Please also keep a copy in the patient notes.

Version 1.2 (May 2015)

GUIDANCE NOTES

This guidance sets out best practice in terms of what information is shared with the care home when a patient is discharged directly from the Emergency Department (ED).

PATIENT INFORMATION: Please insert the correct patient information including the reason(s) for attendance at ED and the date and time of discharge.

DOCUMENTS RECEIVED FROM LONDON AMBULANCE SERVICE (LAS): Please indicate the documents that have been transferred with the patient. Please transfer these documents to the patient's notes.

DIAGNOSIS

Diagnosis on Discharge: Please use this space to record the diagnosis on discharge, including any acute changes.
TTA: Please confirm if there is any medication to take away.
ED Area: Please tick area of ED the patient was seen in. This will enable care home staff to interact directly with the department if any further clarification is required or if a follow up is needed.
Investigations: Use this space to document the investigations which took place while the patient was in ED such as blood tests, CT Scans or X-rays. This will avoid any duplication when the patient returns to the care home setting and will also ensure the GP is aware of the investigations that took place. Please also indicate the outcome of the investigations.

INTERVENTIONS

Medication: Please use this space to indicate the name and dosage of any medication administered to the patient while in ED. This will help with medication reconciliation and ensure safe medication for the patient.
Fluid: Please use this space to indicate the name and dosage of any fluids administered to the patient while in ED. This information is recorded to highlight rehydration therapy and treatment of electrolyte imbalance.
Dressings: Please indicate if dressings were applied to any wound. If yes, please note the type of dressing.
Pressure areas: Please indicate if there are pressure areas. If yes, please note the grade. It is important to note changes to pressure areas/skin to ensure preventative measures are taken and treatment given.
Sutures: Please indicate if any sutures have been applied. If yes, please note the amount and site. This will enable further management of the wound in the care home setting.
Catheter Care: Please indicate if the patient had a catheter inserted prior to ED presentation.

- If yes, please note what type of catheter was inserted and whether the patient discharged with a Catheter Passport. All information in regards to the reasons for the catheter and future management should be documented using the Catheter Passport.
- TWOC Appointment - please indicate who will make an appointment with the TWOC Clinic.

INFORMATION SENT TO GP

Please indicate if the discharge summary has been sent to the patient's GP (GP contact details can be found in the *Transfer Form: Care Homes to Hospital* which should have come with the patient when they were presented to ED). A copy of the discharge information should also be sent with the patient on discharge.

DNACPR Form

Please indicate here if a copy of the DNACPR form has been discharged with the patient. This question is only appropriate for patients who have a DNACPR form.

FOLLOW UP/REFERRALS

Please use this space to document any follow up actions/referrals that must be carried out by the care home. Also note here if any referrals have been carried out by ED staff during the patient's visit.

ADVISORY LEAFLET

Please indicate if an advisory leaflet was given to the patient on discharge. If not, please indicate the reason.