DEPARTMENT OF HEALTH

# Community-Wide Transfer Agreement between Hospitals and Related Health Facilities in the Minnesota Seven County Metropolitan Area

## INCLUDING: ANOKA, CARVER, DAKOTA, HENNEPIN, RAMSEY, SCOTT AND WASHINGTON COUNTIES

The hospitals and related health facilities located in the seven-county metropolitan area of Minnesota do hereby join together, in the following community-wide transfer agreement. The purpose of this agreement is to provide health care most suited to the individual (patients/residents) needs. This agreement shall operate to promote optimum use of the acute care facilities of general hospitals and of the post-acute care services of related health facilities. This agreement shall comply with appropriate requirements of the federal government and the state licensing agencies.

Now, therefore, the hospitals and related health facilities which are signatory below, in consideration of the mutual advantages occurring to all, do hereby covenant and agree each with the other as follows:

1. The governing body of the hospital signatory below and the governing body of the related health facility signatory below shall have exclusive control of the management, assets, and affairs of their respective facilities. No party by virtue of this agreement assumes any liability of any debts or obligations of a financial or legal nature incurred by the other party of this agreement. It is not the intention of either party to create a joint venture with any other party but instead that each party shall operate independent of any other party in the discharge of any obligations assumed by it and the receipt of any agreed compensation to be paid by it.
2. No clause of this agreement shall be interpreted as authorizing either signatory facility to look to the other signatory facility to pay for services rendered to an individual transferred by virtue of this agreement, except to the extent that such liability would exist separate and apart from this agreement.
3. When an individual's need for transfer has been determined by the individual's physician, the referring facility shall promptly notify the receiving facility of the impending transfer. The receiving facility agrees to admit the individual as promptly as possible, provided all conditions of eligibility for admission are met and bed space is available to accommodate that individual.
4. Both signatory facilities agree to provide medical and other related information necessary to ensure continuity of care from one facility to another. Each facility will at minimum provide a patient transfer form similar to the model attached which will accompany the transfer of the individual. Each facility will provide for the security and accountability of the patients personal effects, particularly money and valuables, and will provide an itemized list of such items accompanying the individual.
5. The referring facility shall arrange for safe and appropriate transportation and for care of the individual during transfer.

6. Neither signatory facility shall use the name of the other signatory to this transfer agreement in any promotional or advertising materials unless review and written approval of the intended use is first obtained from the party whose name is to be used.
7. This agreement shall be, and remain, in force from the time of signing as long as it is not renounced by either signatory facility in writing to the other signatory giving ninety (90) days notice. This agreement does not constitute an endorsement of either signatory facility and it shall not be so used.

# Request to Become a Party to the Community-Wide Transfer Agreement of the Minnesota Seven County Metropolitan Area

The following named facility desires to become a party to the seven-county metropolitan area of Minnesota (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington) community-wide transfer agreement.

In witness whereof, the facility named below has executed this agreement this

_____of _____
(day) (month and year)

Name of Facility: _____

Address: _____

City/Zip:_____

Signature: _____

Title: _____

Please complete and send to:

Minnesota Department of Health
Health Regulation Division
Licensing and Certification Program
85 East Seventh Place
P.O. Box 64900
St. Paul, Minnesota 55164-0900

# Patient Transfer Form

Name _____ Phone_____
Last First (MI)

Home Address _____
(City, State, ZIP Code)

Birth Date _____ Age ___ Sex_____ S M W D Sep. _____
(Religion)

Relative or
Guardian_____
(Relationship)

Address _____ Phone_____

Attending
Physician_____ Phone_____

Consulting
Physician(s)_____ Phone_____

Physician
after transfer _____ Phone_____

From _____

To _____
(Name of Hospital, Nursing Home, Agency)

Adm. Date_____Discharge Date_____

Previous Hospitalization and/or Nursing Home Stay (within last 90 Days)

Health Insurance Info. Soc. Sec. No._____

Medicare_____

Medicaid _____

Other_____

## Medical Summary (to be signed by physician)

Discharge Diagnosis

Primary

Secondary

ALLERGIES ☐ Yes ☐ No Type _____

Course of Treatment (include medical/surgical procedures done and date)

Aware of Dx: Patient: ☐ Yes ☐ No Family: ☐ Yes ☐ No

## Physician Orders

ADMIT ☐ Home Health Agency

TO ☐ Nursing Home:

1. ☐ Skilled Care Nursing Facility
2. ☐ Orders effective for 30 days 60 days 90 days (unless specified otherwise)

☐ Other _____

DIET: ☐ Regular ☐ Other _____

ACTIVITY: (List activity level, restrictions and/or precautions, etc.)

SPECIAL TREATMENTS (Including Physical Therapy, Speech, O.T., etc.) Specify Frequency

REHABILITATION POTENTIAL/PROGNOSIS
(Describe the highest level of independent functioning the patient can be expected to achieve)

DRUGS (Generic equivalent may be dispensed unless checked here ☐)

HE-01136-03 _____ M.D. Phone _____ Date _____
(Signature of Physician)

## Patient Care Summary

### Activities of Daily Living

| Self Care Status (✓ level) | Indep. | Assist | Unable | Add. Comments |
|---|---|---|---|---|
| Bathes Self | | | | |
| Dresses Self | | | | |
| Feeds Self | | | | |
| Oral Hygiene | | | | |
| Shaves Self | | | | |
| Transfers Self | | | | |
| Ambulates | | | | |

✓ if Uses: ☐ walker ☐ crutches ☐ cane ☐ wheelchair

Sleep Habits _____

### Physical Traits (Check if applicable)

Impairments ☐ speech ☐ hearing ☐ visual ☐ sensation ☐ other

Disabilities ☐ amputation ☐ paralysis_____ (Describe)

☐ contractures _____ (Describe) ☐ foot drop R_____L_____

Prosthesis ☐ dentures-partial _____ upper_____lower_____

☐ eyes R _____L_____ ☐ glasses ☐ contact lenses

☐ hearing aid ☐ limb RA _____ LA _____LL_____RL_____

### Dietary Information

(Describe appetite, special needs, likes/dislikes, tube feeding, the time of last feeding, etc.)

### Bowel/Bladder

☐Continent ☐Incontinent

Bladder control (Date cath. inserted_____ )
(Date cath. last changed _____ )

Bowel control (Date of last BM _____ )
(Date of last enema _____ )

☐ toilet ☐ commode ☐ bedpan ☐ urinal

Bladder/Bowel Program ☐Yes ☐No

Comments

### Vital Signs

(last T _____ P ____ R ____ BP_____ Wt. _____ Ht._____ )

### Skin Condition

(List according to number and describe)

1. Potential decubiti. 2. Existing decubiti. 3. Draining wound 4. Rash 5. Other

### Current Medications

Time of last medication(s) on day of transfer _____

Effective PRN meds (state reason for and freq. given) _____

Antibiotics received during present stay ☐Yes ☐No Type: ____

_____

New meds_____

### Behavior/Mental Status

☐Alert ☐Oriented ☐Confused ☐Forgetful ☐Wanders

☐Noisy ☐Depressed ☐Combative ☐Withdrawn ☐Other

Comments_____

### Social-Emotional

Prior to Present Pt. Lived: ☐ alone ☐ with friends ☐ boarding home ☐ with family ☐ nursing home ☐ other_____

Advised of Transfer

☐ Patient ☐ Family_____

(List according to number) 1. Attitude toward illness or disease 2. Adjustment/coping ability 3. Emotional support from family/friends 4. Feeling about transfer 5. Financial 6. Other

### Additional Patient Care Information

ATTACH ADDITIONAL PAGE IF NECESSARY. Describe special treatment(s) or condition(s), details of care, safety measures, teaching done and/or needed, level of pt. understanding, and other pertinent information.

### Valuable Accompanying Pt.

(Money, Prosthesis, Jewelry)

Copies sent: ☐H&P ☐Discharge Summary ☐Chest X-ray ☐Lab

☐Other_____

_____ Date_____
(Signature of Nurse)

Unit _____Phone _____Ext. _____