MEDICAL CARE REFERRAL FORM

USE IN ALL SITUATIONS WHEN A RESIDENT HAS A NEW PROBLEM AND INFECTION MAY BE SUSPECTED, AND IS BEING REFERRED TO A MEDICAL CARE PROVIDER, INCLUDING TRANSFER TO AN EMERGENCY DEPARTMENT OR HOSPITAL.

To_____ Phone _____ Fax _____

Resident Name _____DOB __ __/__ __/__ __ Room # _____

From_____ Phone_____Date_____Time_____

Family Contacted: Yes/No If YES, name and relationship_____ Contact Date_____ Time_____

DESCRIPTION OF CURRENT PROBLEM including recent fever pattern and change in recent/current health status:_____

_____

_____

_____

CURRENT VITAL SIGNS

Blood pressure: _____
Pulse: _____
Respiratory rate: _____
Highest temperature in last 24 hours: _____
How taken: _____
3 most recent routine temperatures and how taken:

Temp	How taken:
_____	_____
_____	_____
_____	_____

Shaking chills in last 24 hours: Yes No ?

USUAL COGNITIVE FUNCTION

Good Questionable Impaired

RECENT/CURRENT HEALTH STATUS

New or worsening confusion	Yes	No	?
New or worsening agitation	Yes	No	?
Decrease in eating or drinking	Yes	No	?
Sleepiness/decreased alertness	Yes	No	?
Decline in function	Yes	No	?
Fall	Yes	No	?
If Yes:			
Witnessed	Yes	No	?
Hit head	Yes	No	?
Lost consciousness	Yes	No	?
Suspected minor injury	Yes	No	?
Suspected serious injury	Yes	No	?

MEDICAL HISTORY

Diabetes:	Yes	No	?
If Yes, most recent blood sugar:_____			
COPD:	Yes	No	?
Indwelling catheter:	Yes	No	?
On hospice care:	Yes	No	?
Advanced directive/			
MOST Form:	Yes	No	?
DNR	Yes	No	?
No Antibiotics	Yes	No	?
MEDICATION ALLERGIES:	Yes	No	?

List:_____
_____
_____
_____

Put an "X" in the box to indicate the suspected infection and circle related signs/symptoms Y (present), or No (not present), or ? (not known).

O Suspected Urinary Tract Infection	
Y N ?	New or increased urgency of urination
Y N ?	New or increased frequency of urination
Y N ?	New or increased suprapubic tenderness
Y N ?	Costovertebral angle (CVA) tenderness If yes, new onset: Y N ? If yes, increasing: Y N ?
Y N ?	Painful or difficult urination
Y N ?	Obvious blood in urine
Y N ?	Change in urine appearance or odor
Y N ?	New or worse urinary incontinence
Y N ?	Positive culture If yes, positive for:_____

O Suspected Skin or Soft Tissue Infection	
Location:	
Y N ?	New or increasing pus draining from wound
Y N ?	New breakdown
Y N ?	New or expanding redness around wound
Y N ?	Pain / tenderness
Y N ?	Warmth
Y N ?	New or increased swelling at the site
Y N ?	Increased odor
Y N ?	Ulcer for 3 or more weeks

O Suspected Respiratory Infection	
Y N ?	New cough
Y N ?	Increasing cough
Y N ?	Productive cough If yes, with purulent sputum: Y N ?
Y N ?	Sore throat
Y N ?	Chest X-ray If yes, pneumonia infiltrate: Y N ?
Y N ?	Body aches
Y N ?	Headache
Y N ?	Runny nose and/or sneezing
Y N ?	Shortness of breath
Y N ?	Pleuritic chest pain (painful to take deep breath)
O2 saturation, baseline: _____%	
O2 saturation, current: _____%	

O Suspected Gastrointestinal Infection	
Y N ?	Vomiting: Number of times in past 24 hours: _____
Y N ?	Diarrhea: Number of times in past 24 hours: _____
Y N ?	Other vomiting or diarrhea in the community
Y N ?	Positive culture If yes, positive for:_____

FOLLOW-UP

Was resident hospitalized for this infection? Yes ____ No__

Was culture done? No __ Yes __ If yes, give date, site cultured, and organisms:

_____

_____

_____

If culture done, was one of the following isolated? MRSA __ VRE __ ESBL: _____

If resident treated in facility, complete the following:

Date of antibiotic start:_____

Rx Day 3 ["timeout"]: Improved:_____ No change in status: _ Culture results if any:_____

_____

Provider updated: No ____ Yes ___ Date: _____

Antibiotic rx: Discontinued __ Continued ____

Date antibiotic rx completed:_____

Outcome of infection: Resolved:_____Same or better condition __ More dependent __ Deceased ____
Hospitalized/readmitted _____ Date of readmission _____

Report prepared by:_____ Date initial report:____Date of final report:____