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CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Skilled Nursing Facility (SNF) Transfer Checklist

SNF Name: _____ **Discharging Hospital:** _____

Patient Name: _____ **Patient HICN*** (last four digits only): _____

Diagnosis: _____ **Hospital Discharge Date** (MM/DD/YYYY)**:** ___ /___ /_____

Place an "X" in each circle below to indicate the record/form is present

1. History and Physical ◯

2. Face Sheet ◯

3. Reconciled Medication List ◯

4. Final Physician Orders for SNF Admission ◯

5. Prescription/order for Schedule II controlled substance ◯

6. Informed Consent for Psychotropic Drug Treatment (if applicable) ◯

7. Discharge Summary/Summary of Care ◯

8. Relevant Diagnostic Reports (performed less than 7 days before SNF admission) ◯

9. Vaccination Record ◯

10. Physician Orders for Life-Sustaining Treatment (POLST) Form ◯

11. IV Antibiotic Therapy (if applicable) ◯
a. Medication administered via PICC**? Y N
b. If Yes, is PICC Placement Verification Form present? Y N

12. Documentation of culture and antimicrobial susceptibility test results with applicable dates? Y N
(check all that apply):
a. ◯ MRSA b. ◯ VRE c. ◯ *C. difficile*
d. ◯ *Acinetobacter* resistant to carbapenem antibiotics
e. ◯ *E. coli*, *Klebsiella* or *Enterobacter* resistant to carbapenem antibiotics (CRE)
f. ◯ *E. coli* or *Klebsiella* resistant to expanded-spectrum cephalosporins (ESBL)
g. ◯ Other:_____
(e.g., lice, scabies, disseminated shingles, norovirus, flu, TB, etc.)

13. Currently on Isolation Precautions? Y N
If Yes, check: ◯ Contact ◯ Droplet ◯ Airborne
◯ Other: _____

14. Current devices (check all that apply)**:**
a. ◯ Central line/PICC. Date inserted: ___/___/___
b. ◯ Hemodialysis catheter ◯ Other urological devices
c. ◯ Urinary catheter. Date inserted: ___/___/___
d. ◯ Subrapubic catheter
e. ◯ Percutaneous gastrostomy tube ◯ Artificial feeding ◯ Other nutritional devices
f. ◯ Tracheostomy g. ◯ Fecal management system

Completed by (Please print):

Contact information of discharging RN:

*Health Insurance Claim Number (HICN) **Peripherally inserted central catheter (PICC)

Glossary of Terms:

Discharge Summary/Summary of Care—Document that accompanies the patient to the next setting of care that promotes patient safety during transitions, particularly during the initial post-hospital period. The Joint Commission has established standards (IM.6.10, EP 7) outlining the components that each hospital discharge summary should contain: reason for hospitalization, significant findings, procedures and treatment provided, patient's discharge condition, patient and family instructions (as appropriate), and attending physician's signature.[1]

Face Sheet—A one-page summary of important information about a patient. It includes patient identification, past medical history, medications, allergies, upcoming appointments, insurance status, or other pertinent information.[2]

Final Physician Orders for SNF Admission—Written orders of discharging physician related to SNF admission, such as occupational therapy and urinary catheter insertion.

Informed Consent—Legal document that contains the consent by a client for a proposed mental health or psychotherapeutic procedure.[3]

PICC Placement Verification Form—Documentation of x-ray/EKG confirmation of tip placement.

POLST Form—A preprinted and signed doctor's order that describes the patient's code directions. It also summarizes the wishes regarding life sustaining treatment identified in an advance directive such as a healthcare directive or durable power of attorney for healthcare. It includes patient wishes for: resuscitation, medical interventions, antibiotics, and artificial feedings.[4]

Relevant Diagnostic Reports—Documentation of findings and interpretation of diagnostic tests pertinent to the SNF admitting diagnosis (e.g., a patient admitted for urinary tract infection must include a urine culture).

Reconciled Medication List—Produced by discharging unit personnel (including, but not limited to physician, nurse, pharmacist, etc.) who reconciled the discharge medication list. Should include: new prescriptions, home medications that have not changed, home medications that have changed, and medications that have been discontinued. Can include nonprescription medications and herbal supplements. Should have been compared against patient's home medications list, inpatient medication profile, and prescriptions documented. [5]

Sources:

1. Henriksen, K., Battles, J. B., Keyes, M. A., Grady, M. L., Kind, A. J., & Smith, M. A. (2008). Documentation of mandated discharge summary components in transitions from acute to subacute care.
2. Ibid.
3. Berg, J. W., Appelbaum, P. S., Lidz, C. W., & Parker, L. S. (2001). Informed consent: legal theory and clinical practice.
4. Lee, M. A., Brummel-Smith, K., Meyer, J., Drew, N., & London, M. R. (2000). Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program. *Journal of the American Geriatrics Society*, *48*(10), 1219-1225.
5. Varkey, P., Cunningham, J., O'Meara, J., Bonacci, R., Desai, N., & Sheeler, R. (2007). Multidisciplinary approach to inpatient medication reconciliation in an academic setting. *American Journal of Health-System Pharmacy*, *64*(8), 850-854.

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