READY TO GO FORM

INDIVIDUAL'S INFORMATION Last Updated_____

Name (Last, First, MI)	DOB	Residence Phone	Hospital Preference
Address	Medicaid ID	Medicare ID	Other Insurance
	Language Spoken	Communication	Legal Status
	Religion		

REASON FOR VISIT

To Be completed at time of transfer:
Pre-sedation given prior to leaving residence: Yes ☐ No ☐
If YES to the above, names of medications:
Does the individual have a guardian? Yes ☐ No ☐ If YES, provide name, relationship, and contact number:

CONSENT

Person(s) Authorized to Give Consent:		
Individual		
Name (First and Last)	Relationship	Telephone Numbers (h)
Address (City, State, Zip)		(w) (c)
Name (First and Last)	Relationship	Telephone Numbers (h)
Address (City, State, Zip)		(w) (c)

ADVANCED DIRECTIVES

Non-Hospital DNR Order In Effect? Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
Health Care Proxy? Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
Other Yes ☐ No ☐ Unknown ☐	Attach Copy of Order If Applicable
If YES to Other, specify (i.e. MOLST, Living Will):	

DIET AND CONSISTENCY

ALLERGIES

Medication Allergies (list with description of reaction if known):
Food Allergies (List)
Other (Latex, environmental, etc.)

MEDICATIONS (See Attached Copy of Current Medication Administrative Record)

Routine medication given: If Other, Specify:

READY TO GO FORM

INDIVIDUAL'S NAME:

Last Updated:_____

PRIMARY HEALTH CARE PROVIDER

Name	Address (City, State, Zip)	Phone: Fax:

PHARMACY

Name	Address (City, State, Zip)	Phone: Fax:

MEDICAL HISTORY

Diagnosis
Past Procedures/Surgery

BASELINE

Vital Signs	T	P	R	BP	HT	WT	WT Date
Neurological/Mental Status (describe typical)							
Behavioral (PICA, etc.)							

IMMUNIZATIONS (most recent)

Tetanus Date	Pneumovax Date	Influenza Date	Varicella Date	Varicella Status	Other
TB Status (mm)	PPD Date	Hepatitis B Status	Hepatitis C Status		

ADDITIONAL CONTACT INFORMATION

Agency Name: Administrator/designee	Telephone Day Time: After Hours:
RN	Telephone Day Time: After Hours:
Service Coordinator	Telephone Day Time: After Hours:
Other Relationship	Telephone Day Time: After Hours:

INDIVIDUAL'S NAME: Last Updated:_____

ADDITIONAL INFORMATION
Other: