



Rhode Island Department of Health CONTINUITY OF CARE FORM

Instructions

Fill in all applicable information on pages 1-4. Use N/A in sections that do not apply to patient.

Include the patient's full name on all pages.

If the patient is being transferred to another facility the **patient demographic/registration sheet**, copy of **most recent lab results** and the **last 7 days of medication sheets and IV fluid sheets must** be attached and sent with the Continuity of Care Form (CoC).

CoC Page 1 – General Information:

Patient Name:

Include the patient's full name (Addressograph may be used in right corner if available and clearly legible)

Address:

Include the address at which the patient resided prior to this admission regardless of whether they are returning to that address upon discharge.

Address being discharged to:

Include the address that the patient will be going to upon discharge if different from the patient's home address

Phone: Include the telephone number at the address the patient is being discharged to

Discharging Facility: The name of your facility

Contact Person:

The person who should be contacted regarding questions concerning this patient's stay at your facility

Phone/Beeper: The telephone number/beeper number of the contact person listed above

Insurer: The patient's insurance provider Number: The patient's policy number for Insurer.

Inpatient Admission Date:

The actual date that the patient was admitted as an inpatient at your facility (DO NOT include dates that the patient may have been on "Observation" since this is an outpatient status).

Discharge Date: The date the patient is discharged from your facility

Referral to:

Insert the name of the facility or the name of the visiting nurse agency that the patient is being referred to for post discharge care.

Phone: The telephone number where the above can be contacted

SHADED AREAS TO BE FILLED OUT BY PHYSICIAN:

Principal Diagnosis of this Admission: The diagnosis(es) the patient was being treated for in this facility.

Other Active Medical Problems: List all of the patient's other current/active diagnoses



CoC Page 1 continued:

Surgery this Admission: List all surgeries performed on this patient that took place during this admission.

Date: List the dates of the above surgeries

Infections this Admission and Site:

List all infections that the patient had during this admission and the site of each infection.

If the patient has/or has had MRSA, VRE, and/or C-Diff infections fill in the appropriate box:

Active: Check the box if the patient currently has the infection

Resolved Date: Write in the date the patient was noted to have the infection resolved

Prior History: Check the box if the patient has a history of the infection prior to admission to your facility but it has resolved

Does the patient have an Advanced Directive?

Includes Durable Power of Attorney for Health Care, Living Will

No: Check this box if the patient does not have any advanced directives

Yes: Check this box if the patient does have an advanced directive

FULL: Check this box if the patient is a full code

DNR: Check this box if the patient has a “Do Not Resuscitate” order while in your facility

CMO: Check this box if the patient has an order for “Comfort Measures Only” while in your facility

Immunization(s) this Admission:

FLU: Check this box if the patient had the Influenza Vaccine while in your facility

Pneumovax: Check this box if the patient had the Pneumonia Vaccine while in your facility.

Tuberculin Status, if known:

Neg: Check this box if the patient had a negative result from PPD or chest X-ray in the past 3 months

Positive: Check this box if the patient has ever had a positive PPD or chest X-ray

Unknown: Check this box if you do not know that tuberculin status of this patient

Allergies, list and describe reaction:

List all known allergies and describe what happens during an allergic reaction to each.

Physician orders/treatments. Please specify number and frequency: List all orders for treatment and care post discharge, including the number of times and frequency of each. Be sure to include the patient’s diet, activity orders, and condition at discharge.

All medication(s) to be taken post discharge including those taken prior to admission:

List all orders for medication to be given post discharge, be sure to include route, dosage and frequency for each medication.



CoC Page 2 – General Information:

Patient's Name: Include the patient's full name

Instructions Until Next Doctor Visit:

Check off the boxes that indicate whether the patient is allowed, needs supervision, or is not allowed to perform each activity listed during the time period from discharge to their next physician visit

Physician's Signature: and **Date:**

The signature of the physician completing/verifying the physician orders/treatments, medications, and instructions on pages 1 & 2 of this form and the date completed.

Information given to patient on discharge:

Check off the boxes that indicate the information given to the patient on discharge and complete the remainder of this section to include when to call the physician, follow-up appointments (if known) and any wound instructions.

MEDICATIONS ON DISCHARGE:

1. If the patient is being discharged to home: List the medications the patient will be taking after discharge and the time the next dose is due. **Check the box if prescriptions were given to the patient/guardian for new medications.
2. If the patient is being transferred to another facility: Attach a copy of the most current medication sheet(s). The sheet(s) should be reviewed for accuracy and signed by the discharging nurse.

Nurse's signature and Date: and **Patient/Guardian's signature and Date:**

After reviewing the instructions with the patient/guardian, page 2 should be signed and dated by the nurse and the patient/guardian



CoC Page 3: Physical & Functional Status

Patient's Name: Include the patient's full name

Activities of Daily Living on Discharge Day:

On the day the patient is being discharged from your facility put the appropriate code for how the patient actually self performed the following activities:

ADL DEFINITIONS:

Transfer: How the patient moves between surfaces – i.e., to/from bed to chair, wheel chair or standing position (exclude from this definition movement to/from bath or toilet).

Walking: How the patient walks from place to place.

Dressing: How the patient puts on, fastens, and takes off all items of clothing.

Eating: How the patient eats and drinks, regardless of skill. Includes intake of nourishment by other means (i.e., tube feeding, total parenteral nutrition).

Toileting: How the patient uses the toilet room, commode, bedpan or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

Bathing: How the patient takes a full-body bath/shower or sponge bath and transfers in/out of tub/shower. Exclude washing of back and hair.

Personal Hygiene: How the patient maintains personal hygiene including: combing hair, brushing teeth, applying makeup and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

SELF PERFORMANCE CODES:

0 = Independent: No help or staff oversight provided during activity

1 = Supervision: Oversight, encouragement or cueing provided during activity

2 = Limited Assistance: Patient highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance

3 = Extensive Assistance: Weight bearing support was provided but patient performed/assisted in part of the activity

4 = Total Dependence: Full staff performance of the activity, no participation from the patient in all aspects of the ADL definition

5 = Activity did not occur: The ADL activity was not performed by the staff or the patient

MOBILITY:

Upper Extremities: Check "Normal" if the patient has full range of motion on both sides, Check "Impaired" if the patient has limitations on one or both sides (Include fingers, wrists, and shoulders)

Lower Extremities: Check "Normal" if the patient has full range of motion on both sides, Check "Impaired" if the patient has limitations on one or both sides (Include hips, knees, and ankles)

Amputee:

Check this box if the patient has any amputations and state location of amputation on the line provided

Prosthesis use:

Check this box if the patient uses any prostheses and state type of prosthesis on the line provided

Equipment needed on discharge:

Include all equipment the patient will need for ADL performance/support post discharge, i.e., standard walker, rolling walker, left lower leg prosthesis, weighted utensils, etc.



CoC Page 3 continued:

Stage and locate on diagram all decubitus ulcers:

Include all pressure ulcers the patient currently has and stage as follows:

- Stage 1:** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- Stage 2:** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
- Stage 3:** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
- Stage 4:** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Other wound present, describe: Include all other open areas and describe size and appearance

BOWEL AND BLADDER:

Bowel/Bladder Program – specify:

If the patient is on a bowel or bladder program, include the name of that program, i.e., bowel retraining, bladder retraining, prompted voiding, habit training, scheduled toileting

Bladder Continence (choose one response): Put a checkmark for the best response:

Continent: Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

Occasionally incontinent: Incontinent episodes occur two or more times per week but not daily

Frequently incontinent: Incontinent episodes tend to occur daily, but has some bladder control present

Incontinent: Has inadequate bladder control, incontinence occurs multiple times daily

Bowel Continence (choose one response): Put a checkmark for the best response:

Continent: Complete control (including control achieved by care that involves habit training, reminders, etc.)

Occasionally incontinent: incontinent episodes occur once a week

Frequently incontinent: incontinent episodes occur 2-3 times per week

Incontinent: Has inadequate bowel control, incontinence occurs all (or almost all) of the time

Ostomy – (type/size): include type of ostomy: i.e., colostomy, ileostomy, nephrostomy & size of appliance

Date of last BM: record the date the patient last had a bowel movement.

Date foley changed: record the date the foley was last changed or date of insertion if not changed.

Foley type and balloon size: record the type of catheter inserted and size of the balloon

Dialysis (type): If applicable, record the type of dialysis i.e. hemodialysis, peritoneal, etc.

VITAL SIGNS

Height: Record the patient's most recent height

Weight: Record the patient's most recent weight

Pulse range: Record the patient's pulse range over the past week

Resp. range: Record the patient's respiration range over the past week

Temp: Record the patient's temperature range over the past week

BP: Record the patient's blood pressure range over the past week

Pulse ox range: Record the patient's pulse ox range over the past week when not in oxygen

On Oxygen: Record the patient's pulse ox range over the past week while in oxygen

Pain score (1-10): If your facility uses a different pain scale to measure pain, please convert your answer to scale of 1 – 10



CoC Page 3 continued:

COGNITIVE STATUS

How well does the patient make decisions about organizing the day? (Choose one response):

Independent: The patient's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.

Modified Independence: The patient organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations

Moderately Impaired: The patient's decisions were poor; the patient required reminders, cues, and supervision in planning, organizing, and correcting daily routines

Severely Impaired: The patient never (or rarely) made decisions

Level of consciousness: Check only one response as they are listed below:

- Alert, Drowsy but arousable with minor stimulation;**
- Requires repeated stimulation to respond**
- Responds only with reflex motor or autonomic system**
- Effects or totally unresponsive**

Mini Mental Health Examination: Check all that apply:

Patient is oriented to _____ person _____ year _____ place

Thought or speech organization, coherent

Maintains attention, not easily distracted

Short term memory okay – recalls 3 items (book, tree, house) after 5 minutes

COMMUNICATION

Primary Language: Record the language that the patient primarily speaks or understands in the space provided. Is the patient able to **Understand, Speak, Read,** and/or **Write** in the primary language? Check all that apply.

Secondary Language: If the patient speaks/understands a language other than the primary language, record that language in the space provided. Is the patient able to **Understand, Speak, Read,** and/or **Write** in the secondary language? Check all that apply.

Aphasia: Check if the patient has **Expressive** Aphasia or **Receptive** Aphasia

Sign Language: Check **yes** if the patient uses sign language, check **no** if the patient does not

IMPAIRMENTS – HEARING/VISUAL

Auditory (with hearing appliance if the patient uses one) Check the appropriate response(s):

Hears adequately: The patient hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities

Minimal difficulty: The patient hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations

Intermittently impaired: Although hearing deficient, the patient compensates when the speaker adjusts tonal quality and speaks distinctly; or the patient can hear only when the speaker's face is clearly visible



CoC Page 3 continued – Impairments – Hearing/Visual

Highly impaired: The patient hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Has hearing device:**

Check this if patient uses a hearing device and specify type used on the line provided

Vision (with glasses/visual appliance if used - i.e. eyeglasses, contact lenses or a magnifying glass for close vision)

Adequate: The patient sees fine detail, including regular print in newspapers/books;

Impaired: The patient sees large print, but not regular print in newspapers/books;

Moderately impaired: The patient has limited vision, is not able to see newspaper headlines

Severely impaired: The patient has no vision, sees only light, colors or shapes; or eyes do not appear to follow objects (especially people walking by)

Uses visual appliance:**

Check this if patient uses a visual appliance and specify type of visual appliance used

COMMENTS:

Describe any deviation in the patient’s physical and/or functional status not addressed in the nursing discharge summary or in the above information

Nurse signature, Title and Date: and Patient/Guardian’s signature and Date:

The nurse completing this section must sign and date it.

CoC Page 4 - Specific Discipline Summary Notes:

Patient’s Name: Include the patient’s full name

Nursing Discharge Summary:

This summary should be a brief description of the patient’s stay at your facility along with the reason for the referral or transfer. This section should be used to communicate pertinent specific details regarding patient needs/preferences that would enhance the continued care of the patient. Information regarding **IV** is important and should be completed as appropriate.

Other Disciplines:

All disciplines involved with the care of this patient should complete a summary of their interventions in the additional squares. All sections should contain the discipline, signature and title of the person completing the section, the date and their telephone number.

CoC Page 5 - Continuity of Care Form: Consultation/Referral Form

Provide basic, essential information when referring a resident/patient for additional assessment or evaluation by other health professionals.