CVH-254 **CONNECTICUT VALLEY HOSPITAL** Name _____

New 5/18 **NURSING TRANSFER REASSESSMENT** MPI # _____

(Completed by the RN transferring the patient/receiving the patient) *Print or Addressograph Imprint*

[ ] Addiction Services Division
[ ] General Psychiatry Division

Transfer From: _____ To: _____ Date of Transfer: _____ Legal Status: _____

Reason for Transfer: _____

Allergies: _____

A. MENTAL STATUS AT TIME OF TRANSFER:

TRANSFERRING RN *(Check all that apply and comment)*	**RECEIVING RN** *(Check all that apply and comment)*
1. **Thought Content:** [ ] appropriate [ ] hallucinations [ ] obsessive [ ] disorientation [ ] delusional [ ] confusion [ ] phobic [ ] suspicious [ ] compulsive [ ] other COMMENTS: _____	1. **Thought Content:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____
2. **Thought Process:** [ ] appropriate [ ] blocking [ ] tangential [ ] ideas of reference [ ] circumstantial [ ] other [ ] racing COMMENTS: _____	2. **Thought Process:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____
3. **Motor Behavior:** [ ] appropriate [ ] tics [ ] pacing [ ] repetitive movements [ ] hyperactive [ ] other [ ] hypoactive COMMENTS: _____	3. **Motor Behavior:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____
4. **Speech:** [ ] appropriate [ ] slow [ ] rapid [ ] mute [ ] pressured [ ] other [ ] slurred COMMENTS: _____	4. **Speech:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____

TRANSFERRING RN *(Check all that apply and comment)*	RECEIVING RN *(Check all that apply and comment)*
5. **Communication**: [ ] appropriate [ ] neologisms [ ] non-verbal [ ] word salad [ ] aphasic [ ] stuttering [ ] confabulation [ ] other [ ] incoherent COMMENTS: _____	5. **Communication:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____
6. **Mood**: [ ] appropriate [ ] euphoric [ ] anxious [ ] lethargic [ ] depressed [ ] demanding [ ] angry [ ] sad [ ] apathetic [ ] other [ ] tearful COMMENTS: _____	6. **Mood:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____
7. **Affect**: [ ] appropriate [ ] cheerful [ ] labile [ ] other [ ] flat COMMENTS: _____	7. **Affect:** Change from that recorded by transferring RN? [ ] No [ ] Yes Comments: _____

INFORMATIONAL SECTION	COMPLETED BY TRANSFERRING RN
8. **Sleep/Rest:** [ ] restful [ ] early awakening [ ] insomnia [ ] dreams [ ] nightmares [ ] naps during day [ ] terrors [ ] hyperinsomnia [ ] sleep walking [ ] other	**Number of hours:** _____ COMMENTS: _____
9. **Nutrition:** Diet: _____ Appetite: [ ] appropriate [ ] voracious [ ] diminished [ ] other	COMMENTS: _____
10. **Personal Hygiene:** [ ] good [ ] fair [ ] bad	COMMENTS: _____
11. **Elimination** [ ] within normal limits [ ] concerns	COMMENTS: _____

Name: _____ MPI #: _____

INFORMATIONAL SECTION	COMPLETED BY TRANSFERRING RN
B. RISK ASSESSMENT:	COMMENTS: _____
1. **Suicide Risk:** [ ] Current [ ] History of	_____ _____
2. **Violence Risk:** [ ] Current [ ] History of	COMMENTS: _____ _____ _____
3. **AWOL Risk:** [ ] Current [ ] History of	COMMENTS: _____ _____ _____

C. BEHAVIORAL CONCERNS/INTERVENTIONS: _____

_____

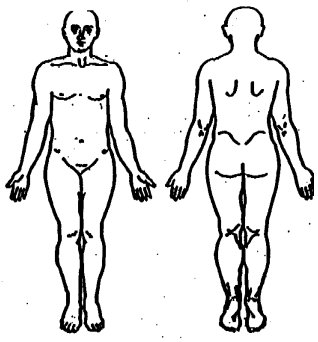
_____

_____

_____

_____

D. PHYSICAL ASSESSMENT AT TIME OF TRANSFER:



1. **Female: LMP** _____
2. **Detoxification Status** *(Addiction Services Division)*: ____

_____

_____

_____

Medical Concerns/Interventions: _____

_____

_____

_____

_____

_____

_____

INFORMATIONAL SECTION **COMPLETED BY TRANSFERRING RN**

E. FUNCTIONAL ASSESSMENT AT TIME OF TRANSFER (i.e., ADL's) *Check all that apply and comment*:

[ ] Independent _____

[ ] With Prompting _____

[ ] With Supervision _____

[ ] With Partial Assistance _____

[ ] With Total Assistance _____

F. MEDICATION CONSIDERATIONS: [ ] None

[ ] Specify: _____

_____

Currently on a High Alert Medication (i.e., Fluphenazine injectible, Insulin, Haloperidol injectible, Heparin, Medoxy Progesterone injectible, Opiates) and/or medications such as Lithium, Clozapine or Warfarin which require increased monitoring?

[ ] No [ ] Yes – *Specify*: _____

_____

TRANSFERRING RN *(Check all that apply and comment)*	**RECEIVING RN** *(Check all that apply and comment)*
G. NURSING CARE PLAN UPDATED PRIOR TO TRANSFER: [ ] Yes [ ] No *Reason:* _____	**G. NURSING CARE PLAN UPDATED FOLLOWING TRANSFER:** [ ] Yes [ ] No *Reason:* _____
H. SCHEDULED APPOINTMENT & LAB WORK [ ] None Pending Labs: [ ] No [ ] Yes – *Specify*: _____ _____ Medical Appointment: [ ] No [ ] Yes – *Specify*: _____ _____	**H. APPOINTMENT AND LAB NOTED** [ ] Yes [ ] N/A Reviewed Lab Values: [ ] Yes [ ] No
I. PRE-TRANSFER VISIT: [ ] Yes [ ] No *Reason:* _____	**I. ORIENTED TO UNIT:** [ ] Yes [ ] No *Reason:* _____

Signature
Transferring RN: _____

Date: _____ Time: _____

Signature
Receiving RN: _____

Date: _____ Time: _____