Minnesota Department of Health
Health Policy, Information and Compliance Monitoring Division

COMMUNITY-WIDE TRANSFER AGREEMENT

BETWEEN

HOSPITALS

AND

RELATED HEALTH FACILITIES

IN THE

SEVEN COUNTY METROPOLITAN AREA OF MINNESOTA INCLUDING:

ANOKA
CARVER
DAKOTA
HENNEPIN
RAMSEY
SCOTT
WASHINGTON

The hospitals and related health facilities located in the 7 County Metropolitan area of Minnesota do hereby join together, in the following community-wide transfer agreement. The purpose of this agreement is to provide health care most suited to the individual (patients/residents) needs. This agreement shall operate to promote optimum use of the acute care facilities of general hospitals and of the post acute care services of related health facilities. This agreement shall comply with appropriate requirements of the Federal Government and the state licensing agencies.

Now, therefore, the hospitals and related health facilities which are signatory below, in consideration of the mutual advantages occurring to all, do hereby covenant and agree each with the other as follows:

1. The governing body of the hospital signatory below and the governing body of the related health facility signatory below shall have exclusive control of the management, assets, and affairs of their respective facilities. No party by virtue of this agreement assumes any liability of any debts or obligations of a financial or legal nature incurred by the other party of this agreement. It is not the intention of either party to create a joint venture with any other party but instead that each party shall operate independent of any other party in the discharge of any obligations assumed by it and the receipt of any agreed compensation to be paid by it.

2. No clause of this agreement shall be interpreted as authorizing either signatory facility to look to the other signatory facility to pay for services rendered to an individual transferred by virtue of this agreement, except to the extent that such liability would exist separate and apart from this agreement.

3. When an individual's need for transfer has been determined by the individual's physician, the referring facility shall promptly notify the receiving facility of the impending transfer. The receiving facility agrees to admit the individual as promptly as possible, provided all conditions of eligibility for admission are met and bed space is available to accommodate that individual.

4. Both signatory facilities agree to provide medical and other related information necessary to ensure continuity of care from one facility to another. Each facility will at minimum provide a patient transfer form similar to the model attached which will accompany the transfer of the individual. Each facility will provide for the security and accountability of the patients personal effects, particularly money and valuables, and will provide an itemized list of such items accompanying the individual.

5. The referring facility shall arrange for safe and appropriate transportation and for care of the individual during transfer.

6. Neither signatory facility shall use the name of the other signatory to this transfer agreement in any promotional or advertising materials unless review and written approval of the intended use is first obtained from the party whose name is to be used.

7. This agreement shall be, and remain, in force from the time of signing as long as it is not renounced by either signatory facility in writing to the other signatory giving ninety (90) days notice. This agreement does not constitute an endorsement of either signatory facility and it shall not be so used.

REQUEST TO BECOME A PARTY TO THE COMMUNITY-WIDE TRANSFER AGREEMENT OF THE SEVEN COUNTY METROPOLITAN AREA OF MINNESOTA

THE FOLLOWING NAMED FACILITY DESIRES TO BECOME A PARTY TO THE SEVEN-COUNTY METROPOLITAN AREA OF MINNESOTA (ANOKA, CARVER, DAKOTA, HENNEPIN, RAMSEY, SCOTT AND WASHINGTON) COMMUNITY-WIDE TRANSFER AGREEMENT.

IN WITNESS WHEREOF, THE FACILITY NAMED BELOW HAS EXECUTED THIS AGREEMENT THIS _____OF_____.
(Day) (Month and Year)

NAME OF FACILITY: _____

ADDRESS: _____

CITY/ZIP: _____

SIGNATURE: _____

TITLE: _____

Please complete in duplicate and send the original to:

Minnesota Department of Health
Health Policy, Information and Compliance Monitoring Division
Licensing and Certification Program
85 East Seventh Place, P.O. Box 64900
St. Paul, Minnesota 55164-0900

(Retain one copy for your files.)

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PATIENT TRANSFER FORM

Name _____ Phone _____ From _____
Last First (MI)

Home Address _____ To _____
(City, State, ZIP Code) (Name of Hospital, Nursing Home, Agency)

Birth Date _____ Age ____ Sex _____ S M W D Sep. _____ Adm. Date _____ Discharge Date _____
(Religion)

Relative or Guardian _____ Previous Hospitalization and/or Nursing Home Stay (within last 90 Days)
(Relationship)

Address _____ Phone _____ Health Insurance Info. Soc. Sec. No. _____

Attending Physician _____ Phone _____ Medicare _____

Consulting Physician(s) _____ Phone _____ Medicaid _____

Physician after transfer _____ Phone _____ Other _____

MEDICAL SUMMARY (to be signed by Physician)

Discharge Diagnosis
Primary

Secondary

ALLERGIES ☐ yes ☐ no Type _____

Course of Treatment (include Medical/Surgical Procedures done and Date)

Aware of Dx: Patient ☐ yes ☐ no Family ☐ yes ☐ no

PHYSICIAN ORDERS

ADMIT ☐ Home Health Agency

TO ☐ Nursing Home: 1. ☐ Skilled Care Nursing Facility

2. ☐ Orders effective for 30 days 60 days
90 days (unless specified otherwise)

☐ Other _____

DIET: ☐ Regular ☐ Other _____

ACTIVITY: (List activity level, restrictions and/or precautions, etc.)

SPECIAL TREATMENTS (Including Physical Therapy, Speech, O.T., etc.)
Specify Frequency

REHABILITATION POTENTIAL/PROGNOSIS
(Describe the highest level of independent functioning the patient can be expected to achieve)

DRUGS (Generic equivalent may be dispensed unless checked here ☐)

HE-01136-03 _____ M.D. Phone _____ Date __
(Signature of Physician)

PATIENT CARE SUMMARY

ACTIVITIES OF DAILY LIVING

Self Care Status (Y level)	Indep	Assist	Unable	Add. Comments
Bathes Self				
Dresses Self				
Feeds Self				
Oral Hygiene				
Shaves Self				
Transfers Self				
Ambulates				

Y if Uses: ☐ walker ☐ crutches ☐ cane ☐ wheelchair

Sleep Habits _____

PHYSICAL TRAITS (Check if applicable)

Impairments ☐ speech ☐ hearing ☐ visual ☐ sensation ☐ Other

Disabilities ☐ amputation ☐ paralysis _____ (Describe)

☐ contractures _____ (Describe) ☐ foot drop R _____ L _____

Prosthesis ☐ dentures-partial _____ upper _____ lower _____

☐ eyes R _____ L _____ ☐ glasses ☐ contact lenses

☐ hearing aid ☐ limb RA ___ LA ____ LL ____ RL ____

DIETARY INFORMATION

(Describe appetite, special needs, likes/dislikes, tube feeding, the time of last feeding, etc.)

BOWEL/BLADDER Continent	Incontinent
Bladder control (Date cath. inserted _____) (Date cath. last changed _____) Bowel control (Date of last BM _____) (Date of last enema _____)	

☐ toilet ☐ commode ☐ bedpan ☐ urinal

Bladder/Bowel Program Yes ☐ No ☐

Comments

VITAL SIGNS (last T _____ P _____ R _____ BP _____ Wt. _____ Ht. _____

SKIN CONDITION: (List according to number and describe)
1. Potential decubiti. 2. Existing decubiti. 3. Draining wound 4. Rash
5. Other

CURRENT MEDICATIONS

Time of last medication(s) on day of transfer _____

Effective PRN meds (state reason for and freq. given _____

Antibiotics received during present stay ☐ Yes ☐ No Type: _____

_____

New meds _____

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Confused ☐ Forgetful ☐ Wanders

☐ Noisy ☐ Depressed ☐ Combative ☐ Withdrawn ☐ Other

Comments _____

SOCIAL-EMOTIONAL

Prior to Present Pt. Lived: ☐ alone ☐ with friends ☐ boarding home

☐ with family ☐ nursing home ☐ other _____

Advised of Transfer

☐ Patient ☐ Family _____

(List according to number) 1. Attitude toward illness or disease
2. Adjustment/coping ability 3. Emotional support from family/friends 4. Feeling about transfer 5. Financial 6. Other

ADDITIONAL PATIENT CARE INFORMATION

ATTACH ADDITIONAL PAGE IF NECESSARY. Describe special treatment(s) or condition(s), details of care, safety measures, teaching done and/or needed, level of pt. understanding, and other pertinent information.

VALUABLE ACCOMPANYING PT.

(Money, Prosthesis, Jewelry)

Copies sent:

☐ H&P ☐ Discharge Summary

☐ Chest X-ray ☐ Lab

☐ Other _____

_____ Date _____

(Signature of Nurse)

Unit _____ Phone _____ Ext. _____