TRANSFER AGREEMENT

BETWEEN A

HOSPITAL

AND A

RELATED HEALTH FACILITY

IN THE

STATE OF MINNESOTA
The ____________________________ hospitals and the ____________________________ related health facility do hereby join together in the following 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 hospital and of the postacute care services of the related health facility. This agreement shall comply with appropriate requirements of the Federal Government and the state licensing agencies.

Now, therefore, the hospital and related health facility which are signatory below, in consideration of the mutual advantages occurring to both 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 patient’s 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 TRANSFER AGREEMENT

THE FOLLOWING FACILITIES DESIRE TO BECOME A PARTY TO A TRANSFER AGREEMENT.

IN WITNESS WHEREOF, THE FACILITIES NAMED BELOW HAVE EXECUTED THIS AGREEMENT THIS ___________ OF _________________________________.

(Day) (Month and Year)

NAME OF HOSPITAL: ____________________________________________

ADDRESS: _____________________________________________________

CITY/ZIP: __________________________ COUNTY: ___________________

SIGNATURE: ___________________________________________________

TITLE: _________________________________________________________

NAME OF RELATED HEALTH FACILITY: _____________________________

ADDRESS: _____________________________________________________

CITY/ZIP: __________________________ COUNTY: ___________________

SIGNATURE: ___________________________________________________

TITLE: _________________________________________________________

Please complete in duplicate and send the original to:

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

Please retain a copy in the files of each facility.
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ADDRESS: ______________________________________________________________________

CITY/ZIP: ___________________________ COUNTY: _______________________

SIGNATURE: ________________________________________________________________

TITLE: _______________________________________________________________________

NAME OF RELATED HEALTH FACILITY: _____________________________________________

ADDRESS: ______________________________________________________________________

CITY/ZIP: ___________________________ COUNTY: _______________________

SIGNATURE: ________________________________________________________________

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PATIENT TRANSFER FORM

Name ____________________________ Phone ____________________________ From ____________________________
Last First (MI)

Home Address ____________________________________________________________
(City, State, ZIP Code)

To ____________________________________________________________ (Name of Hospital, Nursing Home, Agency)

Birth Date _______ Age _____ Sex _____ S M W D Sep. _______ Adm. Date _______ Discharge Date _______

Relative or Guardian ________________________________________________________ (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 ____________________________

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 ____________________________

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

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)

HE-01136-03 ____________________________ M.D. Phone ____________________________ Date ____________________________

(Signature of Physician)
### PATIENT CARE SUMMARY

#### ACTIVITIES OF DAILY LIVING

<table>
<thead>
<tr>
<th>Self Care Status (level)</th>
<th>Indep</th>
<th>Assist</th>
<th>Unable</th>
<th>Add. Comments</th>
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- ✔️ if Uses: walker crutches cane wheelchair
- ✗️ if Uses: walker crutches cane wheelchair

#### 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

#### PHYSICAL TRAITS (Check if applicable)

- Impairments ☐ speech ☐ hearing ☐ visual ☐ sensation ☐ Other

- Disabilities ☐ amputation ☐ paralysis ☐ contractures ☐ foot drop R ☐ L ☐

- Prosthesis ☐ dentures-partial ☐ upper ☐ lower ☐

- ☐ eyes R ☐ L ☐ glasses ☐ contact lenses ☐

- ☐ hearing aid ☐ limb RA ☐

#### 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 ☐

- New meds ___________

#### VALUABLE ACCOMPANYING PT. (Money, Prosthesis, Jewelry)

- Copies sent:
  - ☐ H&P ☐ Discharge Summary
  - ☐ Chest X-ray ☐ Lab
  - ☐ Other ___________

#### BEHAVIOR/MENTAL STATUS

- Alert ☐ Oriented ☐ Confused ☐ Forgetful ☐ Wanders ☐

- Noisy ☐ Depressed ☐ Combative ☐ Withdrawn ☐ Other ☐

- Comments

**Signature of Nurse** ___________  Date ___________

**Unit** ___________  **Phone** ___________  **Ext.** ___________