

Minnesota Department of Health
Facility & Provider Compliance Division

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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SIGNATURE: _____

TITLE: _____

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PATIENT CARE SUMMARY

ACTIVITIES OF DAILY LIVING					SOCIAL-EMOTIONAL
Self Care Status (✓ level)	Indep	Assist	Unable	Add. Comments	Prior to Present Pt. Lived: <input type="checkbox"/> alone <input type="checkbox"/> with friends <input type="checkbox"/> boarding home <input type="checkbox"/> with family <input type="checkbox"/> nursing home <input type="checkbox"/> other _____ Advised of Transfer <input type="checkbox"/> Patient <input type="checkbox"/> 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
Bathes Self					
Dresses Self					
Feeds Self					
Oral Hygiene					
Shaves Self					
Transfers Self					
Ambulates					
✓ if Uses: <input type="checkbox"/> walker <input type="checkbox"/> crutches <input type="checkbox"/> cane <input type="checkbox"/> wheelchair Sleep Habits _____					
PHYSICAL TRAITS (Check if applicable) Impairments <input type="checkbox"/> speech <input type="checkbox"/> hearing <input type="checkbox"/> visual <input type="checkbox"/> sensation <input type="checkbox"/> Other Disabilities <input type="checkbox"/> amputation <input type="checkbox"/> paralysis _____ (Describe) <input type="checkbox"/> contractures _____ <input type="checkbox"/> foot drop R ____ (Describe) L _____ Prosthesis <input type="checkbox"/> dentures-partial ____ upper ____ lower ____ <input type="checkbox"/> eyes R ____ L ____ <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> hearing aid <input type="checkbox"/> 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 _____)					
<input type="checkbox"/> toilet <input type="checkbox"/> commode <input type="checkbox"/> bedpan <input type="checkbox"/> urinal					
Bladder/Bowel Program Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ New meds _____			VALUABLE ACCOMPANYING PT. (Money, Prosthesis, Jewelry)		
BEHAVIOR/MENTAL STATUS <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Wanders <input type="checkbox"/> <input type="checkbox"/> Noisy <input type="checkbox"/> Depressed <input type="checkbox"/> Combative <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other Comments _____			Copies sent: <input type="checkbox"/> H&P <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Chest X-ray <input type="checkbox"/> Lab <input type="checkbox"/> Other _____		
_____ Date _____ (Signature of Nurse) Unit _____ Phone _____ Ext. _____					