

**McLaren Print System Order**

**Order No: 6438**  
**Order Date: 2014-10-14**  
**User: anna parsian**  
**Phone: 810-342-2375**

**Ship Location: Debra Hoffman/Anna**  
**401 South Ballenger Hwy - 4 South**  
**Flint , MI 48532**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 91570**  
**Dept Name: Case Management 4-South**  
**Company Number: 60**

**Order Total Price: 59.75**

**Item Number: 17598-B**  
**Item Description: Discharge by Transfer (with III. Nursing)**  
**Revision Date:**  
**Print: 1 sided black and white**  
**Paper: 2 Part (White, Yellow)**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: 5 Hole Top**  
**Misc Info:**

**McLaren Flint  
 Flint, Michigan**

**DISCHARGE BY TRANSFER**

**III. NURSING (Complete & Sign)**

| <table border="1"> <tr><th>Admission</th><th>Discharge</th><th>Transfer</th></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>  | Admission  | Discharge  | Transfer |  |  |  |  |  |  |  |  |  | <p><b>SELF CARE STATUS</b><br/>                 (Check and initial. Write 0 in space if none apply.<br/>                 Leave only 0 for the score if applicable.)</p> <p>Star _____<br/>                 Activity _____<br/>                 Personal Hygiene _____<br/>                 Transfer _____</p> | <p><b>CHECK IF PRESENT</b></p> <p><b>DEBARMENTS</b><br/> <input type="checkbox"/> Abuse<br/> <input type="checkbox"/> Child Abuse<br/> <input type="checkbox"/> Child Neglect<br/> <input type="checkbox"/> Child Molestation<br/> <input type="checkbox"/> Child Sexual Abuse<br/> <input type="checkbox"/> Child Sexual Abuse<br/> <input type="checkbox"/> Child Sexual Abuse<br/> <input type="checkbox"/> Child Sexual Abuse<br/> <input type="checkbox"/> Child Sexual Abuse</p> <p><b>SEX</b><br/> <input type="checkbox"/> Male _____<br/> <input type="checkbox"/> Female _____<br/> <input type="checkbox"/> Transsexual _____<br/> <input type="checkbox"/> Other _____</p> <p><b>Behavior</b><br/> <input type="checkbox"/> Aggressive<br/> <input type="checkbox"/> Belligerent<br/> <input type="checkbox"/> Belligerent<br/> <input type="checkbox"/> Belligerent<br/> <input type="checkbox"/> Belligerent</p> <p><b>Communication Ability</b> Yes No<br/>                 Can speak English <input type="checkbox"/> <input type="checkbox"/><br/>                 Does not speak English <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Patient Care</b><br/> <input type="checkbox"/> Assistance <input type="checkbox"/> Clothing <input type="checkbox"/> Care<br/> <input type="checkbox"/> Nutrition <input type="checkbox"/> Hydration <input type="checkbox"/> Medication<br/> <input type="checkbox"/> Other</p> |
|--|--|--|----------|--|--|--|--|--|--|--|--|--|---|---|
|  | Admission  | Discharge  | Transfer |  |  |  |  |  |  |  |  |  |   |   |
|  |  |  |          |  |  |  |  |  |  |  |  |  |   |   |
|  |  |  |          |  |  |  |  |  |  |  |  |  |   |   |
|  |  |  |          |  |  |  |  |  |  |  |  |  |   |   |
| <p><b>HEALTH STATUS</b><br/>                 (Check and initial)<br/>                 Conscious <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/><br/>                 Alert <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/><br/>                 Oriented <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/><br/>                 Family contact preferred <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> | <p><b>VITAL SIGNS</b>    T    P    R    S    Temp</p> <p>Sleep problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/><br/>                 Confused in bed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | <p>Summary _____</p> <p>Nurses Signature _____ RN Date _____/_____/____ Time _____ Report called to receiving facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |          |  |  |  |  |  |  |  |  |  |   |   |
| <p><b>IV. SOCIAL WORK</b> (Complete if applicable)<br/>                 Advance directives? <input type="checkbox"/> Yes <input type="checkbox"/> No    Code/Status _____<br/>                 Advance Plan    Discussed with: <input type="checkbox"/> SO <input type="checkbox"/> Patient <input type="checkbox"/> Family<br/>                 Referral made to: _____<br/>                 Summary _____</p>  |  |  |          |  |  |  |  |  |  |  |  |  |   |   |
| <p>Signature and title _____</p> <p style="text-align: center;"><b>DISCHARGE BY TRANSFER</b><br/>                 (Print Name/Title)</p> <div style="text-align: center;">  <p>0500</p> </div>  |  |  |          |  |  |  |  |  |  |  |  |  |   |   |