TRANSFER OF CARE FROM HOSPITAL PLANNING QUESTIONNAIRE

Surname	MRN
Given Name	Male Female
D.O.B: ____ / _____ / _____	M.O.
Address	
Location/ward	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Name / Known as:

Are you (is the person) of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐

Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

If Yes, refer to Aboriginal Liaison Service. ☐

You are presently on the waiting list for surgery at _____. To assist with planning for your hospitalisation and transfer home, would you please complete these questions by ticking the appropriate box/es. If you require help, ask your family, carer or local doctor.

	Office Use Only
1. Age _____	
2. Do you speak English at home? If no, which language do you speak: ☐ No ☐ Yes _____	Yes? Action: Book interpreter ☐
3. Do you need a professional interpreter? ☐ No ☐ Yes	
3. Do you have problems with your memory? Has your doctor talked with you about cognitive impairment, dementia or previous delirium? ☐ No ☐ Yes	Yes? Action: For PAC ☐
4. What is your understanding of how long you will be in hospital? Day only ☐ Overnight ☐ 1-2 days ☐ 2-5 days ☐ Unsure ☐ More than 1 week ☐	Is this correct? Y ☐ N ☐→ Action
5. Have you made arrangements for someone to take you home from hospital? (A responsible adult must accompany Day Only patients home, and must stay with them at least for the first night after surgery). ☐ No ☐ Yes	No? Action: Contact patient ☐
6. Do you live: Alone ☐ With family ☐ With carer ☐ Nursing home ☐ 7. Where do you live: House/unit ☐ Boarding house ☐ Hostel ☐ Other: _____	Alone, boarding house, hostel? Action: Contact patient ☐
8. Do you care for another person on a regular basis? ☐ No ☐ Yes	Yes, then No? Action: Contact patient ☐
9. Have alternative arrangements been made to look after this person? ☐ No ☐ Yes	
10. Do you normally need assistance to walk? ☐ No ☐ Yes	Yes?→ Look at procedure
11. Do you use a walking aid such as a stick or frame? If yes, what type? ☐ No ☐ Yes _____	Yes?→
12. Do you have stairs at home? If yes, how many and are they indoors/outdoors: ☐ No ☐ Yes _____	Yes?→ Look at procedure
13. Do you have difficulties with your sight? Please describe: ☐ No ☐ Yes _____	Yes?→
14. Do you have any difficulties with your hearing? Please describe: ☐ No ☐ Yes _____	Yes?→ Look at procedure

Appendix 3 – Transfer of Care from Hospital Planning Questionnaire – Adult – 1/2

	Office Use Only
14. On discharge, do you think you will have any problems with:	
Bathing / showering No ☐ Yes ☐	Qs 14 – 17: Yes to any of these?
Dressing No ☐ Yes ☐	Action:
Toileting No ☐ Yes ☐	Referral made: ☐
Cooking No ☐ Yes ☐	Date:_____
Cleaning No ☐ Yes ☐	Discharge planner ☐
Shopping No ☐ Yes ☐	Social worker ☐
Business matters No ☐ Yes ☐	Physiotherapist ☐
Family matters No ☐ Yes ☐	Occ. Therapist ☐
Other: _____ Describe:	
15. On discharge, do you think you will require help at home (that cannot be provided by your current support network)? No ☐ Yes ☐	Document discharge plan ☐
16. What arrangements have been made for someone to care for you when you get home?	
17. Do you currently use any of the following services?	
Community nurse ☐ Personal care assistance ☐ Meals on Wheels ☐	
Home Help ☐ Aboriginal Specific Services ☐ Day care / therapy unit ☐	
Other: ☐ Describe: _____	

Please ask for assistance, as staff are available to assist you with any concerns.

Thank you for completing this form.

The information you have provided will help in planning your transfer of care from hospital.

HOSPITAL USE ONLY

Expected length of stay:		Actions completed:		Intervention required:	No ☐ Yes ☐
Telephone intervention:	No ☐ Yes ☐	Action:			
Screened by: (RN)		Signature:		Date:	
Referrals to be made to:					
Social work ☐		CNC Discharge liaison ☐		Physiotherapy ☐	
Stomal therapy ☐		Occupational therapy ☐		CA/PAC ☐	
Drug & Alcohol ☐		Aboriginal Liaison ☐		Interpreter ☐	
Other: ☐ Describe: _____					
Requires Pre Admission Clinic				No ☐ Yes ☐	
Appointment made by (administrative staff):		Signature:		Date:	
Appointment date:					

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