

MEDICAL CARE REFERRAL FORM

USE IN ALL SITUATIONS WHEN A RESIDENT HAS A NEW PROBLEM AND INFECTION MAY BE SUSPECTED, AND IS BEING REFERRED TO A MEDICAL CARE PROVIDER, INCLUDING TRANSFER TO AN EMERGENCY DEPARTMENT OR HOSPITAL.

To: _____ Phone: _____ Fax: _____
 Resident Name: _____ DOB: ___/___/___ Room #: _____
 From: _____ Phone _____ Date: _____ Time _____
 Family Contacted: Yes No If YES, Name and relationship: _____ Contact Date _____ Time _____

DESCRIPTION OF CURRENT PROBLEM including recent fever pattern and change in recent/current health status:

CURRENT VITAL SIGNS Blood pressure: _____ Pulse: _____ Respiratory rate: _____ Highest temperature in last 24 hours: _____ How taken: _____ 3 most recent routine temperatures and how taken: Temp How taken: _____ _____ _____ _____ _____ _____ Shaking chills in last 24 hours: Yes No ?	USUAL COGNITIVE FUNCTION Good Questionable Impaired RECENT/CURRENT HEALTH STATUS New or worsening confusion Yes No ? New or worsening agitation Yes No ? Decrease in eating or drinking Yes No ? Sleepiness/decreased alertness Yes No ? Decline in function Yes No ? Fall Yes No ? If Yes: Witnessed Yes No ? Hit head Yes No ? Lost consciousness Yes No ? Suspected minor injury Yes No ? Suspected serious injury Yes No ?	MEDICAL HISTORY Diabetes: Yes No ? If Yes, most recent blood sugar: _____ COPD: Yes No ? Indwelling catheter: Yes No ? On hospice care: Yes No ? Advanced directive/ MOST Form: Yes No ? DNR Yes No ? No Antibiotics Yes No ? MEDICATION ALLERGIES: Yes No ? List: _____ _____ _____ _____
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Put an "X" in the box to indicate the suspected infection and circle related signs/symptoms Y (present), or No (not present), or ? (not known).

O Suspected Urinary Tract Infection	
Y N ?	New or increased urgency of urination
Y N ?	New or increased frequency of urination
Y N ?	New or increased suprapubic tenderness
Y N ?	Costovertebral angle (CVA) tenderness If yes, new onset: Y N ? If yes, increasing: Y N ?
Y N ?	Painful or difficult urination
Y N ?	Obvious blood in urine
Y N ?	Change in urine appearance or odor
Y N ?	New or worse urinary incontinence
Y N ?	Positive culture If yes, positive for: _____
O Suspected Skin or Soft Tissue Infection	
Location:	
Y N ?	New or increasing pus draining from wound
Y N ?	New breakdown
Y N ?	New or expanding redness around wound
Y N ?	Pain / tenderness
Y N ?	Warmth
Y N ?	New or increased swelling at the site
Y N ?	Increased odor
Y N ?	Ulcer for 3 or more weeks

O Suspected Respiratory Infection	
Y N ?	New cough
Y N ?	Increasing cough
Y N ?	Productive cough If yes, with purulent sputum: Y N ?
Y N ?	Sore throat
Y N ?	Chest X-ray If yes, pneumonia infiltrate: Y N ?
Y N ?	Body aches
Y N ?	Headache
Y N ?	Runny nose and/or sneezing
Y N ?	Shortness of breath
Y N ?	Pleuritic chest pain (painful to take deep breath)
O2 saturation, baseline: _____%	
O2 saturation, current: _____%	
O Suspected Gastrointestinal Infection	
Y N ?	Vomiting: Number of times in past 24 hours: _____
Y N ?	Diarrhea: Number of times in past 24 hours: _____
Y N ?	Other vomiting or diarrhea in the community
Y N ?	Positive culture If yes, positive for: _____

