Sphinx Home Health Care

TRANSFER OF RESPONSIBILITY FOR PATIENT CARE

Patient Name: _____ MR#_____

Address_____

Contact Person Name: _____ Phone# _____

DISCIPLINE: ☐SN ☐PT ☐OT ☐HHA ☐SLP ☐MSW ☐RD

Dates of Coverage: SOC:_____ From _____ To_____

Frequency of Visits to be covered: _____

Specific Dates to cover:_____

***Primary RN/Therapy/Aide/MSW/OT/SLP/RD TO RESUME CARE ON:_____

Physician Name :_____ Phone#:_____

Diagnosis:_____

Directions to patient's home:_____

_____

***Relief RN/PT/HHA/OT/MSW/SLP/RD Assigned: _____

Date notified/acceptance of assignment:_____

☐ V/S (T, PR, BP) Ranges; _____

☐ Present Wound Description (if applicable) :_____

☐ Present Wound Treatment: _____

Teaching/Interventions/Instructions: _____

_____

_____

LABS:_____

Other:_____

Disciplines: SN_____ Aide_____/Supr Visit due date:_____

PT_____ _____ OT_____ MSW_____

RD_____ SLP_____ PTA/LPN_____

Plan of Care (485) attached: ☐ YES ☐ NO Evaluation/Care plan attached: ☐ YES ☐NO

Any Change in medication(s)? ☐ YES ☐NO / if yes, med Profile copy attached: ☐ YES ☐NO

Remarks: _____

Signature: _____ Date: _____