READY TO GO FORM

INDIVIDUAL'S INFORMATION

Date Updated:

Name (Last, First, MI)	DOB	Residence Phone	Hospital Preference
Address (Street, City, State, Zip)	Medicaid ID	Medicare ID	Other Insurance
	Language Spoken	Communication	Legal Status

REASON FOR VISIT

To be complete at time of transfer:
Pre-sedation given prior to leaving residence: ☐ NO ☐ YES if yes, name of medication:

CONSENT

Person Authorized to Give Consent:	
Individual ☐ NO ☐ YES ☐ Undetermined ☐ Ability to give consent would need to be determined for each separate procedure.	
Name (First and Last) Relationship	Telephone Numbers (h) (w) (c)
Address (Street, City, State, Zip)	
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Address (Street, City, State, Zip)	

ADVANCED DIRECTIVES

Non-Hospital DNR Order in Effect? ☐ NO ☐ YES	Date of DNR Order: Attach Copy of Order if Applicable
Health Care Proxy? ☐ NO ☐ YES	Date of Proxy: Attach Copy of Proxy if Applicable

ALLERGIES

Medication Allergies (list with description of reaction if known):	
Food Allergies (List)	Other (Latex, environmental, etc.)

MEDICATIONS

**** See Attached Copy of Current Medication Administration Record****

Medications given: (Choose route from drop down menu) →

INDIVIDUAL'S NAME: _____

PRIMARY HEALTH CARE PROVIDER

Name	Address: (Street, City, State, Zip)	Phone:
		Fax:

MEDICAL HISTORY

Diagnosis: (one per box)		
Past Procedures/Surgery:		

BASELINE

Vital Signs:	T	P	R	BP	HT	WT	WT Date
Neurological/Mental Status (describe usual):							
Behavioral (PICA, etc.):							

IMMUNIZATIONS (most recent)

Tetanus Date	Pneumovax Date	Influenza Date	Varicella Date	Other
TB Status (mm)	PPD Date	Hepatitis B Status	Hepatitis C Status	Other

ADDITIONAL CONTACT INFORMATION

Agency Name: Administrator/designee	Telephone day time: After hours:
RN	Telephone:
Service Coordinator	Telephone:
Other: Relationship	Telephone:

ADDITIONAL INFORMATION

Other: