TENDER HOME CARE, CORP.

Patient Name: _____ **MR#** _____
Nombre del Paciente

Beneficiary- Elected Transfer
Forma de Elección de transferencia del Paciente

The use of the HIQH (RHHI INQUIRY SYSTEM) has indicated that the beneficiary is under an active episode of care with another Home Health Agency. **The transfer has been elected by the patient or patient representative.** *El uso del sistema informativo HIQH/RHHI indico que el beneficiario esta bajo servicio con otra Agencia,* ***transferirse a nuestra Agencia ha sido elegido por el paciente/representante.***

Complete the following:

1. **The original RHHI** inquiry system was accessed on (date) _____ it was discovered that the patient has an active episode under care with the following agency: _____.
   Fecha en que fue revisado el sistema.

2. The patient's physician (name) _____ was contacted on (date) _____ and approved this transfer.
   El doctor del paciente fue contactado y aprobó el cambio.

3. The patient or patient care giver was notified that the initial H.H.A will no longer receive Medicare payment on (date of transfer) _____ and **agreed to the transfer.**
   El paciente/representante fue notificado que la anterior Agencia no recivirá más pagos por los servicios a partir de la transferencia.

Name of person contacted: _____
Nombre de la persona contactada

Relationship: _____
Relación

4. The initial H.H.A was contacted on (date of transfer) _____ and notified of the transfer to our agency.
   Fecha en que la anterior Agencia fue contactada y notificada de la transferencia

_____ _____
Patient's/Caregiver Signature — Date
Firma del paciente/representate — *Fecha*

_____ _____
Signature/Title of Agency Representative — Date
Firma del representante de la Agencia/Título — *Fecha*

PATIENT TRANSFER SUMMARY TO ANOTHER HEALTHCARE FACILITY

Patient's Name: _____ MR #: _____

Date of transfer: _____ Report date: _____

Other Patient identifying information (Medicare, Medicaid, Insurance): _____
_____

Emergency contact: _____

Destination of patient transferred: _____

Name of person receiving report: _____

Patient's physician and phone number: _____
_____

Diagnosis related to the transfer: _____
_____

Significant health history: _____
_____
_____
_____
_____

Transfer orders and instructions: _____
_____
_____
_____
_____

A brief description of services provided and ongoing needs that cannot be met:, Patient's Status:

_____
_____
_____
_____
_____
_____

_____ _____

Signature & Title of Staff making report Date