Clinical Transition Plan

PURPOSE: To Facilitate the continuity of care for an individual transitioning to alternate placement. The Clinical Transition Plan is intended to supplement the Transition Plan by providing more detailed information relative to the clinical issues.

COMPLETED BY: Professional Nurses and Primary Care Physicians

GENERAL INFORMATION:

1. The entire form is to be completed by a professional nurse, designated by the Director of Nursing, and a Primary Care Physician.

2. The original is to be filed in the medical record with a copy retained by the Habitation Plan Coordinator (HPC) and the designated nurse.

3. When changes to a section occur, the section is to be updated by the designated nurse and/or the Primary Care Physician with a newly completed page and placed in the Clinical Transition Plan in the proper order. The HPC and designated nurse will each retain a copy. The old section should be removed.

4. The Clinical Transition Plan will be reviewed prior to discharge to ensure accuracy. The designated nurse will be responsible for informing the Primary Care Physician that the plan requires updating.

5. The HPC is responsible for ensuring this document is provided to the potential provider when visits are scheduled.

PROCEDURE

1. The Clinical Transition Plan will be initiated when an individual's name is placed on Tier 1. This Plan will be completed prior to the individual visiting a potential community provider.

2. Sections I through IV and Section VI (Nursing) are to be completed by the designated nurse.

3. Section V and Section VI (Physician) are to be completed by the Primary Care Physician.

4. Section VII is to be completed by the designated nurse when the supporting clinical documents are attached to the Clinical Transition Plan packet.

5. The primary care physician and the designated nurse are to sign and date when their sections are completed.

INSTRUCTIONS

1. May use (TAB) key to move forward from field to field and (SHIFT) (TAB) to move back from field to field.

2. May use (ENTER) key to "check" a box.

3. NOTE: If you cannot read all of what you typed in a section (there may be a "+" sign at the end of the typing), only what you can read will be printed.

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SECTION I. General Demographics/Information - Completed by Nursing

Name: _____ DHS ID Number: _____ Age: _____ Date of Birth: _____

Gender: ◯ Female ◯ Male Race: _____ Verbal Skills: _____

Hearing Ability: _____ Visual Ability: _____ Communication: _____

SECTION II. General Medical Information - Completed by Nursing

1. Ambulation

☐ Normal Gait ☐ Non Ambulatory ☐ Abnormal gait, Does not require assistance

☐ Abnormal gait, Requires personal assist ☐ Abnormal gait, Requires physical device

☐ Abnormal gait, Requires physical device and personal assist

Type of Device ☐ W/C ☐ Cane Type: _____ ☐ Walker Type: _____

☐ Independent ☐ Total lift

☐ Mechanical device ☐ Hand on assist of _____staff

☐ SBA ☐ Other: _____

2. Bowel Managment

Self toilets ◯ Yes ◯ No Requires assistance ◯ Yes ◯ No Ostomy ◯ Yes ◯ No

Continent of bowel ◯ Yes ◯ No Diagnosis of constipation ◯ Yes ◯ No

History of bowel obstruction ◯ Yes ◯ No History of bowel perforation ◯ Yes ◯ No

History of bowel surgery/procedure ◯ Yes ◯ No Date/Type: _____

Requires frequent bowel aids (greater than monthly) ◯ Yes ◯ No

3. Aspiration Risk

Is the individual at risk for aspiration? ◯ Yes ◯ No

Type of Risk: ☐ GERD ☐ Sialorrhea ☐ Oral-pharyngeal dysmotilty ☐ Gastroesophageal dysmotility

☐ Diaphragmatic hernia ☐ Other: _____

Has the individual had a Video Swallow Evaluation? ◯ Yes ◯ No Date completed: _____

4. Fall Risk

Is the individual at risk for a fall? ◯ Yes ◯ No Has individual fallen in the past 12 months? ◯ Yes ◯ No

Has the individual sustained a fracture from a fall or unknown mechanism? ◯ Yes ◯ No

Does the individual have a servous orthopedic risk factor? ◯ Yes ◯ No

☐ Moderate to Severe osteoarthritis ☐ Rheumatoid arthritis ☐ Degenerative spine disease

☐ Kyphosis ☐ Scoliosis ☐ Internal orthopedic appliance (artificial joint, stabilizing rod, etc.)

☐ Other: _____

Is there a medical condition that may cause imbalance? ◯ Yes ◯ No ☐ CP ☐ Arthritis ☐ Parkinson's

☐ De-conditioned ☐ Cardiovascular ☐ Abnormal Vision ☐ Other: _____

5. Pulmonary Risk

Does the individual have serious pulmonary risk factors? ◯ Yes ◯ No

☐ COPD ☐ Asthma ☐ Recurrent Pneumonia ☐ Other _____

Respiratory Therapy ◯ Yes ◯ No Details: _____

The individual requires ☐ Bi-Pap ☐ C-Pap ☐ Oxygen ☐ Other Other: _____

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6. Neurological Risk

Does this person have serious Neurologic risk factors? ◯ Yes ◯ No

☐ Stroke ☐ Small Vessel Disease ☐ Dementia ☐ Hydrocephalus ☐ Tardive Dyskinesia

☐ Parkinson's ☐ Prolapsed Disk ☐ Spinal Stenosis ☐ Spasticity ☐ Dystonia ☐ Other _____

Active Seizure Disorder ◯ Yes ◯ No History of seizure disorder ◯ Yes ◯ No

Type of Seizures: _____

Frequency of Seizures (average/month): _____ Duration of Seizure Activity (average in minutes): _____

Date of Last Seizure: _____ Does individual have a VNS? ◯ Yes ◯ No

Will PRN medications be required for management of seizure control? ◯ Yes ◯ No

If "Yes", name/dose/route of medication: _____

7. Cancer Risk

Does the individual have cancer or a history of cancer? ◯ Yes ◯ No

If "yes", Describe type and treatment provided:

8. Administration of Medication

Are there special considerations required for administration of medications? ◯ Yes ◯ No

☐ Compliance issues ☐ Enteral tube ☐ Other: _____

9. Nutritional

Ideal body weight: _____ Current weight: _____ BMI: _____ Height: _____

Individual is underweight: ◯ Yes ◯ No Individual is overweight: ◯ Yes ◯ No

☐ G-Tube Type & Size: _____

☐ J-Tube Type & Size: _____

☐ Other Type & Size: _____

Diet Order: _____

Etiology of abnormal weight: _____

10. Skin Integrity

Is the individual at risk for skin breakdown? ◯ Yes ◯ No Etiology/Treatment: _____

Chronic wounds: ◯ Yes ◯ No Etiology/Treatment: _____

Preventative Measures/Alternate Positioning ◯ Yes ◯ No List: _____

11. Infection Control

Does the individual have an active infectious disease condition? ◯ Yes ◯ No

☐ MRSA ☐ MDRO ☐ C-diff ☐ Pseudomonas ☐ Other (List): _____

Location/details: _____ Is the individual colonized with MRSA: ◯ Yes ◯ No

Location: _____

12. Diabetes

Does the individual have diabetes? ◯ Yes ◯ No ☐ Insulin dependent ☐ Non-insulin dependent

A1C: Date: _____ Value: _____ Diet: _____

Medication(s): _____ ☐ Sliding Scale: _____

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13. Cardiovascular Risk

Does the individual have chronic cardiovascular risk? ◯ Yes ◯ No

☐ Hypertension ☐ Arrhythmias ☐ CAD ☐ CHF ☐ Other: _____

14. Dental Issues

☐ Abscess ☐ Caries ☐ Edentulous ☐ Dentures ☐ Peridontal Disease

☐ Other _____

15. Allergies/Adverse Drug Reactions/Sensitivities

Does the individual have any adverse drug reactions/allergies? ◯ Yes ◯ No

If "Yes", list below, include type of reaction and date (if known):

ADR: _____ Allergy: _____ Sensitivity: _____

SECTION III. Medical Follow-up - Completed by Nursing

1. Hospitalization/Clinical Follow-up

In the past year, has the individual been admitted to an acute facility/emergency room for medical condition? ◯ Yes ◯ No

Date: _____ Facility: _____ Reason: _____

Date: _____ Facility: _____ Reason: _____

Date: _____ Facility: _____ Reason: _____

Date: _____ Facility: _____ Reason: _____

If more room is needed attach a separate sheet of paper.

2. Implanted Devices

Does the individual have an implanted device? ◯ Yes ◯ No

☐ VNS: Date inserted: _____ Date last battery change: _____

☐ Baclofen Pump: Date inserted: _____ Date last fill: _____

☐ Pacemaker: Date inserted: _____ Date last battery change: _____

☐ Portacath: Date inserted: _____ Date last flush: _____

☐ Foley Catheter: Date inserted: _____ Last changed: _____

Catheter size: _____

3. Adaptive or Specialized Equipment

Does the individual require adaptive or specialized equipment (not previously listed)? ◯ Yes ◯ No

☐ Glasses ☐ Hearing Aide R: _____ L: _____ Both: _____ ☐ Adaptive eating utensils:

Type: _____ ☐ Other: _____

4. Protective devices?

Does the individual require protective devices? ◯ Yes ◯ No Type: _____

5. Medical and Dental Support Services

Medical immobilization (Type & Indication):

Anxiolysis (Medication, Indication, Dose):

Desensitization Program: ◯ Yes ◯ No If "Yes", attach support desensitization document.

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SECTION IV. Status of Consultative Services - Completed by Nursing

Cardiology ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

Dental Services ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

ENT ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

Gynecologist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

Hematologist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

Neurologist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

Oncologist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____
Reason for Service: _____
Frequency of Service: _____ Last Date of Services: _____
Contact Information: _____
Recommended appointment date: _____ Actual appointment date: _____

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Optometrist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____

Reason for Service: _____

Frequency of Service: _____ Last Date of Services: _____

Contact Information: _____

Recommended appointment date: _____ Actual appointment date: _____

Othopedist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____

Reason for Service: _____

Frequency of Service: _____ Last Date of Services: _____

Contact Information: _____

Recommended appointment date: _____ Actual appointment date: _____

Podiatrist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____

Reason for Service: _____

Frequency of Service: _____ Last Date of Services: _____

Contact Information: _____

Recommended appointment date: _____ Actual appointment date: _____

Psychiatrist ◯ Yes ◯ No Specialist Name: _____ Telephone: _____

Reason for Service: _____

Frequency of Service: _____ Last Date of Services: _____

Contact Information: _____

Recommended appointment date: _____ Actual appointment date: _____

Other ◯ Yes ◯ No Specialist Name: _____ Telephone: _____

Reason for Service: _____

Frequency of Service: _____ Last Date of Services: _____

Contact Information: _____

Recommended appointment date: _____ Actual appointment date: _____

Other ◯ Yes ◯ No Specialist Name: _____ Telephone: _____

Reason for Service: _____

Frequency of Service: _____ Last Date of Services: _____

Contact Information: _____

Recommended appointment date: _____ Actual appointment date: _____

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SECTION V. Medical/Physical Issues - Completed by Physician

Medical/Physical Problem	Status of Medical/Physical Problem	Follow-up action for clinically significant medical problems (lab tests, evaluations, medication changes, etc.)

SECTION VI. Additional Significant Health Issues

Physician: List and define any additional significant health care precautions to support this individual's needs that are not addressed previously.

Nurse: List and define any additional health care precautions to support this individual's needs that are not addressed previously.

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SECTION VII. Supporting Clinical Documents

Supporting Clinical Documents (Check Box when in Transition Packet)

- ☐ History and Physical
- ☐ Health Risk Screen Tool (HRST)
- ☐ Immunization Record
- ☐ Last DISCUS
- ☐ Transition Plan
- ☐ Medical Consultation Reports
- ☐ Psychiatric Consultation Reports
- ☐ Current Medication Administration Record (MAR)
- ☐ Diagnostics (all MRI/CT Scans, past 24 months EEG, X-Rays, Sleep Studies, VFS, Other relevant studies)

☐ Cardiology	☐ Neurologist	☐ Psychiatrist	☐ Gynecologist
☐ Hematologist	☐ Podiatrist	☐ Gastroenterologist	☐ Optometrist
☐ Orthopedist	☐ ENT	☐ Ophthalmologist	☐ Other _____
☐ Dental	☐ Oncologist	☐ Pulmonologist	☐ Other _____

Date completed: _____

Physician Signature: _____ Date: _____

Registered Nurse Signature: _____ Date: _____