Senior Living link FORUM

Tel: 1-844-480-8572 Fax: 206-826-9173 donna@seniorlivinglink.org

Transition Coordinator Information

Company/Agency Name _____

Your Name _____

Your Email _____

Your Phone _____ Ext. _____

Your Pager _____

Patient Information & Requirements for Care

Preferred Payment Method ☐ Medicaid ☐ Private Pay

Gender ☐ Female ☐ Male

Age _____

Anticipated Discharge Date _____

Location Desired _____

City/County _____

Room Preference

Room Type	☐	Private	☐	Semi Private	☐	Shared
Bathroom Type	☐	Bathtub	☐	Regular Shower	☐	Roll-in Shower

Specialty Care Certifications or Training

Mental Health including Dementia	☐	Optional	☐	Preferred	☐	Required
Developmental Disability	☐	Optional	☐	Preferred	☐	Required

Other, please specify: _____

Services Required (select the care your patient requires)

- ☐ Medication Administration
- ☐ Contagious Disease
- ☐ Wound Care
- ☐ Ventilator Care
- ☐ Ostomy/Colostomy Care
- ☐ Catheter Care
- ☐ Diabetes Management
- ☐ Oxygen Care
- ☐ Feeding or Nasal Tube Care
- ☐ Feeding Assistance
- ☐ Hopsice Care
- ☐ Respite Care

Other, please specify: _____

Please continue to the next page

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Behaviors Accepted

Resistive to Care	☐
Exit Seeking	☐
Combative Behavior	☐
Requires Awake Staff	☐

Other, please specify: _____

Transfer Requirements

One person stand by assist	☐
One person contact assst	☐
Two person transfer	☐
Sliding Board	☐
Hoyer Lift	☐

Other, please specify: _____

Ambulation Requirements

Independent	☐
Walker or other assisted devices	☐
Manual Wheelchair	☐
Electric Wheelchair	☐

Additional Information

Smoking allowed	☐
Pets allowed	☐

Other, please specify: _____

Language(s) Spoken _____

Your listing is complete! Kindly fax to 206-826-8173 or email to donna@seniorlivinglink.org