DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITES SERVICES
COMMUNITY SERVICES

Transfer Planning Conference
Nursing Checklist

Name:_____ Date:_____

Allergies: _____

_____

Insurance: Medicaid:_____

Medicare:_____

Other:_____

Current Pharmacy:_____

Address:_____

_____

Phone:_____

Guardianship:_____

Immunizations	
Tetanus:	MMR:
Influenza:	Pneumovax:
Oral Polio:	Hib:
Hepatitis B Vaccine: #1 _____ #2 _____ #3 _____	PPD: 1st Step: _____ Results: _____ 2nd Step: _____ Results: _____ QuantiFERON-TB Gold Plus: _____ T-SPOT: _____
COVID Vaccine: #1_____ #2_____ Booster #1_____ Booster #2_____	

Health Information	
Physical Date:	ECHAT Date:
SMC Date:	Medical Alert Form Date:
Aspiration/Choking Screening Date:	Fall Risk Screening Date:
Ability to Self-Medicate: ☐Yes ☐ No	Self Admin of Med Assessment Date:
Pap Smear Date:	Mammogram:

Health Information	
Menses:☐ Yes ☐ No ☐	Date of LMP:
Blood Pressure:	Weight:
AIMS Date: Score:	
Current Diet Order:	Medical History:
Mealtime Concerns:	Durable Medical Equipment:
Seizure Disorder: ☐Yes ☐No Description: _____ Frequency: _____ Date of Last Seizure: _____	Therapy Services: ☐Yes ☐ No PT: _____ OT: _____ Speech: _____

Labs and Screenings	
CBC:	Drug Levels:
CMP:	Colon Cancer Screening:
Lipids:	Other:
UA:	
PSA:	

Specialist	**HCP's Name**	**Date of Last Visit**	**Recommended Follow-up**
Primary Care			
Dental			
Audiology (hearing eval.)			
Cardiology			
Dermatology			
ENT			
Endocrinology			
Gastroenterology			
Gynecology			
Nephrology			
Neurology			
Nutrition			
Oncology			
Ophthalmology			
Optometry			
Podiatry			
Psychiatric			