FORM # 691 Transfer

Clark Quality Care

To be completed within 10 days of transfer

NAME:	LOCATION:
MEDICAID#:	DOB:
ADDRESS:	REPRESENTATIVE NAME / NUMBER
DATE OF ADMISSION:	DATE OF TRANSFER:
CSB:	SUPPORT COORDINATOR:

REASON FOR ADMISSION

LEGAL STATUS: (if incompetent, give guardian's name and address, and date of court order)

NAME AND ADDRESS OF NEAREST RELATIVE:

TRANSFER MEDICATIONS: DOSAGE AND TIME: PURPOSE:

REASON FOR TRANSFER:

EMERGENCY MEDICAL INFORMATION:

CURRENT PSYCHIATRIC AND MEDICAL CONDITION:

Clark Quality Care

PROGRESS IN ACHIEVING GOAL AND OBJECTIVES:

CONTINUED CARE RECOMMENDATIONS:

DEGREE OF INDIVIDUAL / AR PARTICIPATION IN THE PLAN PROCESS:

____ **Date:** ________________
Signature / Title of Person Completing Summary

____ **Date:** ________________
Signature of Individual

____ **Date:** ________________
Signature of Guardian / AR

____ **Date:** ________________
Signature of Support Coordinator