Ohio | Department of Developmental Disabilities

TRANSITION PLANNING CHECK LIST				
Name of Individual:	DOB:	Sex:	Height:	Weight:
Does this person have a guardian:	If so, please include name/contact information:			
Reason for transfer/Current Medical/Psychiatric Condition:				
Is transfer considered: Elective or Urgent/Emergency (Please circle one)				
PAST MEDICAL AND PSYCHIATRIC CONDITIONS/DIAGNOSIS:				
MOST RECENT HOSPITLAZATION (MEDICAL/PSYCHIATRIC)-DATE AND REASON:				
PAST SURGERIES-INCLUDE ANY METAL IMPLANTS				
ALLERGIES-PLEASE INCLUDE FOOD, ENVIROMENTAL AND DRUG ALLERGIES:				
DNR STATUS:				
Check here ONLY IF Ohio **DNR-CC or DNR-CCA** is attached_____ (a properly authorized DNR-DNR-CC must be attached to be valid)				
MEDICATIONS-INCLUDE ROUTE AND PLEASE ATTACH A COPY OF MEDICATIONS:				
DIET/SPECIAL TEXTURE/FEEDING TUBE:				
RESPIRATORY CONDITIONS-SLEEP APNEA. INCLUDE OXYGEN OR OTHER EQUIPTMENT USE:				
BEHAVIORAL-PLEASE INCLUDE PICA, SIB, ELOPMENT, ANXIETY AND ANY BEHAVIORAL SUPPORT STRATEGIES				
MOBILITY/AMBULATION- IS THE PERSON AT RISK OF FALLING?				
LIST ANY ADAPTIVE EQUIPMENT NEEDS:				

SPECIAL SENSES-VISION, HEARING-PLEASE INCLUDE ADAPTIVE EQUIPTMENT NEEDS:

COMMUNICATION (BEST METHOD):

MY MEDICAL AND HEALTH INFO:

DATE/COPY OF MOST CURRENT HISTORY AND PHYSICAL:

IMMUNIZATION RECORDS:

IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:	IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:	IMMUNIZATIONS:	DATE LAST GIVEN:	DATE NEXT DUE:
D.P.T			Hep. B			P.P.D.		
Shingles			Flu			Pneumonia		
D.T./T.T.								

LAB ABNORMALITIES:

PREVENTATIVE CARE:

SCREENINGS	DATE LAST GIVEN:	DATE NEXT DUE:	RECOMMENDED FOLLOW UP	SCREENING	DATE LAST GIVEN:	DATE NEXT DUE:	RECOMMENDED FOLLOW UP
COLONSCOPY				MAMMOGRAM			
VISION				PAP SMEAR			
HEARING				PSA			

WHAT IS IMPORTANT TO ME:	**WHATS IMPORTANT FOR ME:**
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IMPORTANT CONTACT:	**IMPORTANT CONTACT:**

_____ _____ _____ _____

Person submitting information Date Person receiving information Date