CoC Advisory Board
Care Transitions Data Sheet

Client Name (If possible): _____ **Date of Birth:** _____

Phone number: _____ **Date & Time of Contact:** _____/_____

Name of Contact Person (Family/Friend):_____ **Relationship**_____

Contact Person Phone Number: _____

Did you just arrive from a:

- ☐ Psychiatric Hospital
- ☐ Medical Hospital
- ☐ Board & Care
- ☐ Community Health Center or Clinic
- ☐ Shelter
- ☐ Skilled Nursing Facility
- ☐ Prison/Jail
- ☐ Other

Where did you most recently discharge from?	**Name of Facility:**
When were you discharged?	**Date:** **Time:**
Do you have documents from the facility? (If yes, confirm discharging facility)	**Yes☐ No☐** **Discharging Facility Confirmed: Yes☐ No☐**
Do you have a name and/or phone number for a contact there? (If yes, please provide)	
How did you get here (to this facility)?	**Walk☐ Taxi☐ Bus☐ Uber/Lyft☐ Other☐**
Did you choose to come here?	**Yes ☐ - Or, I was sent☐ Not sure☐**

	Yes	No	NA
Do you have medications?	☐	☐	☐
Are you able to take your medication independently?	☐	☐	☐
Do you have any wounds?	☐	☐	☐
Do you have dressing supplies?	☐	☐	☐
Are you able to change your dressing?	☐	☐	☐
Do you have diabetes?	☐	☐	☐
Do you have testing supplies?	☐	☐	☐
Are you currently having pain?	☐	☐	☐

Where were you living prior to this last facility?

☐ Homeless ☐ Home ☐ Skilled Nursing Facility
☐ Shelter ☐ Board & Care ☐ Other

Below this line for organization use only.

Name of Person Completing Form:

Date Completed: **Organization:**

Observations: