Functional Pathways™
Excellence in Rehabilitation

SAFE TRANSITION PLANNING TOOL

Name: _____ Discipline(s): PT ☐ OT ☐ ST ☐

Anticipated Transition Date: _____

Considerations for the interdisciplinary team to ensure a safe transition:

Yes ☐	No ☐	Have environmental barriers been identified and addressed to ensure a safe transition? (stairs, narrow hallways, lack of transportation, lack of caregiver support, etc.)
Yes ☐	No ☐	Does the resident have the ability to obtain, self-administer, and manage their medication(s)? If no, have arrangements been made for assistance?
Yes ☐	No ☐	Does the patient require a home visit to ensure optimal safety and independent function in the potential discharge environment?
Yes ☐	No ☐	Is the patient safe from self-harm or injury to others in the performance of functional activities in the potential discharge environment?
Yes ☐	No ☐	Have all short/long term goals been met? If not, have they been modified to address barriers to progress?
Yes ☐	No ☐	Has the interdisciplinary team met with the patient/caregiver to establish a transition plan, including discussion of equipment and follow up care needs in order to allow adequate time to prepare for the transition?
Yes ☐	No ☐	If caregiver support will be required at the discharge location, has this been discussed with the patient/family and arrangements made for the necessary level of caregiver assist?
Yes ☐	No ☐	Has the appropriate team member scheduled follow up appointments and aftercare arrangements (sitter, home health, etc.)?
Yes ☐	No ☐	Has all necessary patient/caregiver teaching and training been completed with return demonstration indicating understanding and independence in all areas?
Yes ☐	No ☐	Have psychosocial needs been addressed?
Yes ☐	No ☐	If patient is returning to an independent living setting, has training been provided in case of natural disasters? This can include patient exiting home in case of a fire, adverse weather, power outages, etc. Does the patient have a method to contact help in case of an emergency?
Yes ☐	No ☐	Has a home exercise program been provided with appropriate training to patient and caregivers to facilitate follow through?
Yes ☐	No ☐	Does the patient need a restorative program for continued maintenance and monitoring safety, if remaining in the SNF?
Yes ☐	No ☐	Has the activities department been apprised of appropriate activities/tasks, if patient to remain in the SNF?
Yes ☐	No ☐	Has the dietary department been notified of any final changes in diet, food presentation, and/or adaptive equipment?
Yes ☐	No ☐	Has the care plan team been notified and the care plan modified to reflect current needs?

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Anticipated Destination:

Private Home/Apt. ☐ ALF ☐ SNF ☐ Other ☐ _____

Support:

Alone ☐ With Family ☐ With Sitter ☐ Other ☐ _____ Caregiver (hrs/day) _____

Checklist for Discharge Destination

Stairs:

Inside _____ # Outside _____ Handrail(s): Right ☐ Left ☐ Both ☐ None ☐

Floors:

Carpet ☐ Rugs ☐ Wood ☐ Tile ☐ Other ☐ _____

Bedroom:

Main Level ☐ Upstairs ☐

Sleeps On:

Bed ☐ Hospital Bed ☐ Recliner ☐ Couch ☐

Bathroom:

Tub ☐ Tub / Shower ☐ Walk-In Shower ☐ Tub Bench ☐ Raised Toilet ☐

Recommendations

Home Evaluation:

Home Eval Needed: Yes ☐ No ☐ Date Completed: _____

If no, indicate reason: _____

Family/Patient/Caregiver Education completed? PT ☐ OT ☐ ST ☐

Therapy Equipment:

Currently Owns: _____

Additional Equipment Needs: _____

Therapy Needs:

Outpatient:	PT ☐	OT ☐	ST ☐
Home Health:	PT ☐	OT ☐	ST ☐
Restorative Nursing:	PT ☐	OT ☐	ST ☐
Home Exercise Program:	PT ☐	OT ☐	ST ☐

Diet Texture and Liquid Viscosity: _____

Additional Comments:

_____

_____

_____

_____

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PHYSICAL THERAPY	OCCUPATIONAL THERAPY	SPEECH THERAPY
Ambulation:	**ADLs/IADLs:**	**Dysphagia:**
☐ Uneven Surfaces	☐ Oral Hygiene	☐ Eats Least Restrictive Diet
☐ Even Surfaces	☐ Grooming	☐ Drinks Least Restrictive Fluids
☐ Curbs	☐ Shaving	☐ Dysphagia Compensatory Strat.
☐ Ramps	☐ Personal Hygiene	☐ Preparation of Altered Diet
☐ Community Distance	☐ Toileting	**Functional Cognition:**
☐ Stairs	☐ Personal Nail Care	☐ Medication Management
☐ Ambulate with LRAD	☐ Retrieve Clothing	☐ Memory
Bed Mobility:	☐ Self Feeding	☐ Money Management
☐ Rolling	☐ Community Transportation	☐ Organization
☐ Scooting	☐ Cooking-Stove/Microwave/Oven	☐ Orientation
☐ Supine ⟷ Sit	☐ Energy Conservation	☐ Reasoning
Transfers:	☐ Food Preparation	☐ Safety Awareness
☐ Bed ⟷ Chair Transfers	☐ Housekeeping	☐ Sequencing
☐ Car Transfers	☐ Judgment/Memory	**Communication:**
☐ Fall Recovery Transfer	☐ Laundry	☐ Able to Communicate Needs
☐ Functional Activity Tolerance	☐ Managing Medication	☐ Able to Follow Commands
☐ Functional Safety Awareness	☐ Money Management	☐ Patient/Caregiver Education
☐ Home Exercise Program	☐ Organization/Sequencing	☐ Reading Comprehension
☐ Restorative Nursing Program	☐ Outdoor Activities/Leisure Skills	☐ Speech is Clear
☐ W/C Management/Mobility	☐ Personal Safety during ADL's	☐ Use of Compensatory Strat.
☐ Wound Management	☐ Using Phone	☐ Written Communication
	☐ Home Exercise Program	☐ Patient/Caregiver Education
	☐ Restorative Nursing Program	☐ Home Exercise Program
		☐ Restorative Nursing Program

Staff in Agreement that:	PT	OT	ST
Patient's individual wants/needs/goals were addressed?	☐	☐	☐
All applicable areas of function have been addressed?	☐	☐	☐
All goals met or all avenues have been exhausted to reach goals?	☐	☐	☐
Patient has reached the highest level of independence needed for the discharge setting?	☐	☐	☐
Patient/Caregiver(s) educated and understand discharge instructions?	☐	☐	☐