|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Label | | **ED Patient Transfer Communication Form**  [Hospital Name and Address]  DRAFT – Sample Items on paper or to incorporate in EMR | | | |
| Transferring Facility | | Transferring Physician | | | |
| Date: / / Time:  The receiving facility has agreed to accept transfer and provide appropriate medical treatment as acknowledged by  **Physician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Transferring MD/DO/Provider**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Specialist Consult: 🞏 Cardiologist 🞏 Pediatrician 🞏 Psych 🞏 Acute Coronary Intervention**  **🞏 Surgery: 🞏** General **🞏** Orthopedic **🞏** Gastrointestinal **🞏** Urology  Other/Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| The receiving facility,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has available space and qualified personnel for treatment as  acknowledged by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit: Bed #  Date: / / Time: **: hrs** | | | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have discussed the report with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, from the receiving hospital  Date: / / Time: | | | | | |
| Patient Significant Other Name and Contact Number:  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: ( ) | | | | | |
| **Documentation sent:**  **🞏** Available via EMR  **🞏** Complete ED Record  **🞏** Face Sheet  **🞏** EKG  **🞏** Lab Results   * X-Ray Results * Neuro Assessment | **🞏** X-Ray films/CD  **🞏** EMTALA  **🞏** Obs/IP Record  **🞏** MAR  **🞏** No medication given in ED | | **Discharge vitals**:  BP \_\_\_\_\_\_  P \_\_\_\_\_  R \_\_\_\_\_  T\_\_\_\_\_  O2 Sat \_\_\_\_  **🞏** DNR | Pain level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Time of last pain med\_\_\_\_\_\_\_\_\_\_\_\_  **🞏** NPO \_\_\_  **🞏** Diet N/A  **🞏** Liquids only \_\_\_  Last Intake time: \_\_\_\_\_\_\_\_\_  **🞏** Advance Directive | |
| Other:  Lab  X-ray results not available at this time – ED will forward when available | | | **Sensory Status: 🞏**  Not Known / No Time to Assess  **See chart for 🞏** Hearing **🞏** Vision **🞏**  Speech **🞏**  Mental  **🞏** Sensation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **🞏** Language Barrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Allergies: 🞏** NKA  **🞏 Yes**  **🞏**Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Other/Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Immobilization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **🞏** See list of home Medication  **🞏** No Home Med **🞏** Unable to determine home meds  **🞏**  IV **🞏** Heparin Lock **🞏** Central Line  **🞏** Urinary **🞏**  NG **🞏** Saline Lock  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **🞏**  O2 at \_\_\_\_\_\_\_\_ L/min  **🞏** Requires suctioning  **🞏**  Intubation  **🞏** Isolation | | **🞏**  Vent   * C-Pap/Bi-Pap   **🞏**  Chest Tube  **🞏** Telemetry |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **RN Name (Print):** | | | **RN Signature:**  Date: / / Time: **: hrs** | | |