|  |  |
| --- | --- |
| 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 LockOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **🞏**  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** |