Patient transfer form (inter-hospital)

Non–time critical patients **Facility name**

Place Health Service Logo Here

Identify

Transfer discussed with patient Yes ☐ No ☐

Date of transfer

Indigenous status (circle)

A / TSI

ATSI / Unknown

Medicare no. _____

Pension / DVA no. _____

Private health insurance (PHI) fund

_____

PHI no.

(Affix patient label here)

Referring facility URN

Surname Given names

Address

Postcode DOB

Gender Male ☐ Female ☐

Allergies Nil known ☐ Yes ☐ (if yes list type, reaction and severity) Signature

General practitioner Yes ☐ No ☐ Unknown ☐

GP name_____

GP phone no. _____

GP notified of transfer Yes ☐ No ☐ Unknown ☐

Next of kin (NOK) / Carer / Substitute decision maker (SDM) (Circle)

Name _____

Phone no. _____

Relationship to patient_____

NOK / Carer / SDM notified of transfer Yes ☐ No ☐

Referring / authorising practitioner name

_____

Referring unit _____

Referrer phone/pager no. _____

Referrer position (Consult / Reg / HMO / GP / RN / Other)

Referring ward

Name _____

Phone no._____

Patient living arrangements

Living independently ☐

Residential facility ☐

In-home support ☐

Situation

Principal diagnosis / problem

Reason for transfer

Medical history / comorbidities

Observations at time of transfer: T_____.P_____ B/P _____

Respiratory management plan / O_2 requirements

$Sp0_2$ target O_2 rate O_2 device*

*If ETT — record any difficulty with intubation.

Intravascular access Site and date of insertion

☐ No access
☐ Peripheral venous line (1) ……
☐ Peripheral venous line (2) ……
☐ Peripheral venous line (3) ……
☐ Central venous line ……
☐ Other ……

IV fluids Yes ☐ No ☐

Mental / cognitive / behaviour

☐ No issues
☐ Cognitive impairment ☐ Post-traumatic amnesia
☐ Verbal aggression ☐ Delirium
☐ Physical aggression ☐ Sleep disturbance
☐ Resistive to care ☐ Dementia
☐ Absconding risk ☐ Depression
☐ Wanderer ☐ Acquired brain injury
☐ Harm to self ☐ Harm to others
☐ Other _____

Current cognitive state _____

Glasgow Coma score

Legal status

☐ Not applicable
☐ Voluntary patient ☐ Involuntary patient
☐ Forensic patient ☐ Security patient

Nutrition and swallowing

Fasting: Yes ☐ No ☐

Time of last intake_____

Diet: Normal Diabetic Renal Soft Puree Minced NBM

Fluids_____

Supplements _____

Restrictions _____

Safe swallow strategies:_____

Medication Crushed ☐ Whole ☐

Enteral feeding NG ☐ PEG ☐

Regime and feed sent Yes ☐ No ☐

Dentures Yes ☐ No ☐

Weight

Continence

☐ No issues
☐ Faecal continence
☐ Urinary continence
☐ Indwelling catheter
☐ Intermittent catheter
☐ Stoma / colostomy

Time last voided

Date bowels last opened

Date IDC inserted

Communication

Interpreter required No ☐ Yes ☐

Primary language spoken

Patient transfer form

MR no.

Form version no. & design date

Patient transfer form

Facility name **Date** **Page 2**

Background

Specialty-specific information

(Affix patient label here)

Referring facility URN

Surname Given names

Address

Postcode DOB

Gender Male ☐ Female ☐

Alerts – none ☐ _____

Alerts – bariatric patient ☐ _____

Alerts – falls risk ☐ _____

Alerts – infectious risk ☐ _____

Alerts – pressure ulcer risk ☐ _____

Alerts – smoker ☐ _____

Advance care directives Yes ☐ No ☐ Unknown ☐

NFR / limitation of medical treatment order Yes ☐ No ☐ Unknown ☐

Alerts – other:

Accompanying Pt.

Personal items	**N/A**	**Accompanying patient**	**Sent with family**
Clothing	☐	☐	☐
Glasses	☐	☐	☐
Dentures	☐	☐	☐
Hearing aid	☐	☐	☐
Medications	☐	☐	☐

Equipment _____

Valuables ☐ ☐

List valuables _____

_____

Other

If an air-ambulance transfer, luggage has to be less than 5 kgs

Patient ID band on patient Yes ☐

Attached copy of documentation: (where applicable)

Doctor's letter	☐	Cognitive assessment tool	☐
Allied health letter	☐	*Advance care directives	☐
Observation chart	☐	Nursing care plan / pathway	☐
Medications chart	☐	Fluid balance chart	☐
IV orders	☐	Behaviour management plan	☐
Wound chart	☐	*Involuntary treatment order	☐

*NFR / limitation of medical treatment order ☐

Investigation results: X-rays ☐ ECG ☐ Pathology report ☐

Other

* Where these exist, a copy **must** accompany the patient

Responsibility

Receiving facility (RF)

Appropriate time for transfer agreed Yes ☐ No ☐

RF name

RF ward name

Acceptance by receiving medical practitioner Yes ☐ No ☐

Date Time

Receiving medical practitioner / unit name

_____

Receiving practitioner / unit phone no. and pager

Acceptance by receiving facility bed coordinator Yes ☐ No ☐

Date Time

Receiving bed coordinator name

_____

Receiving bed coordinator phone no. and pager

Treating allied health contact details (if applicable)

Discipline	Name	Pager/phone	Discipline	Name	Pager/phone
Occupational therapist			Dietitian		
Physiotherapist			Social worker		
Speech pathologist			Other		

Form completed by (print name and job designation) :

Signature:

Patient **transport provider (TP)** service name _____ Date and time booked

Handover received Yes ☐ No ☐

Accompanying documentation received Yes ☐ No ☐

Receiving transport provider name (print)

Signature

Handover provided**:** by referring staff Yes ☐ No ☐ **:** by TP Yes ☐ No ☐.

Accompanying documentation provided Yes ☐ No ☐

Accompanying items checked Yes ☐ No ☐

Receiving clinical staff name (print)

Signature

Fax the form to receiving hospital prior to patient transfer. A copy should accompany the patient and the original form should be filed in the patient medical record.