Patient transfer form (inter-hospital)

Non–time critical patients **Facility name**

PUHMED® RHL HOSPITALS

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

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
Allied health letter
Observation chart
Medications chart
IV orders
Wound chart
*NFR / limitation of medical treatment order
Cognitive assessment tool
*Advance care directives
Nursing care plan / pathway
Fluid balance chart
Behaviour management plan
*Involuntary 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.