PORTLAND
DISTRICT HEALTH

INTER-HOSPITAL PATIENT TRANSFER

U.R Number ……..

Surname ……

Given Name(s) ……..

Date of Birth ……

AFFIX PATIENT LABEL HERE

MR122

Allergy Alert:

No Known Allergies

Signature: _____

Medicare Number:_____ _____

Pension / DVA / Workcover / TAC No.:_____

Private Health Fund:_____

Private Health Membership No:_____

Date of Transfer:

Transfer discussed with patient (please circle): YES NO

Primary Language:

Interpreter required (please circle): YES NO

Is patient of Aboriginal or Torres Strait Island origin? (please circle) YES: **A / TSI / ATSI** NO UNKNOWN

General Practitioner

GP Name: _____

GP Phone No : _____

GP notified of transfer (circle): YES NO UNKNOWN

Next of Kin (NOK)/ Carer

Name: _____

Phone No_____ Relationship:_____

NOK notified of transfer(circle): YES NO UNKNOWN

Referring Practitioner

Name: _____

Phone No : _____

Position: Consult / Reg / HMO / GP / RN / Other

Referring Unit

Unit Name: _____

NUM Name: _____

Phone No : _____

Patient Living arrangements

Independent ☐

Residential facility ☐

In home support ☐

Principal Diagnosis

Reason for Transfer:

Past Medical History / Co-morbidities

Behaviour

- □ Harm to self
- □ Harm to others
- □ Mechanical restraint
- □ Pharmacological restraint
- □ Voluntary Patient
- □ Involuntary Patient

GCS: _____/15

Current Cognitive State:

Respiratory Management Plan / O_2 Requirements

SpO_2 Target: _____ O_2 Rate: _____ O_2 Device: _____

	Intravascular Access	**Site & Date of insertion**
□	Peripheral venous line (1)	_____
□	Peripheral venous line (1)	_____
□	Peripheral venous line (1)	_____
□	Central Venous line	_____
□	Other	_____
□	No access	**IV Fluids:** YES NO

Faecal Continence	YES	NO
Urinary Continence	YES	NO
Indwelling catheter	YES	NO
Date IDC inserted:	_____	
Intermittent catheter	YES	NO
Stoma/Colostomy	YES	NO
Time last voided:	_____	
Time bowels last opened:	_____	

Fasting from:

FOOD: YES NO

FLUIDS: YES NO

Time of last intake: _____

Nasogastric / PEG tube:

YES NO

Other:

C-SPINE immobilised:

YES NO N/A

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Speciality Specific Information

Alerts

- ☐ Forensic Patient _____
- ☐ Bariatric Patient _____
- ☐ Infectious Risk _____
- ☐ Pressure Ulcer risk _____

Alerts – Other:

Hearing _____ Aid ☐

Vision _____ Aid ☐

Mobility _____ Aid ☐

Falls Risk _____

Weight _____ Dietary Needs: _____

Advance Care Directives:

YES NO UNKNOWN

NFR/Limitation of Medical Treatment Order (LOMT):

YES NO UNKNOWN

Personal Items	N/A	Accompanying Patient	Sent with family
Clothing	☐	☐	☐
Glasses	☐	☐	☐
Dentures	☐	☐	☐
Medications	☐	☐	☐
Equipment			
Valuables (specify)		☐	☐
Other			

Investigation results:

Xrays ☐ **Other**

Pathology Report ☐

ECG ☐

Attached copy of: (where applicable)

Doctor Letter	☐	Cognitive Assessment Tool	☐
Allied Health letter	☐	Advance Care Directives	☐
Observation Chart	☐	Nursing Care plan/pathway	☐
Medication Chart	☐	Fluid balance chart	☐
IV orders	☐	Behaviour Management Plan	☐
NFR/ LOMT	☐	Other	☐

Receiving Facility (RF)

RF Name:

Appropriate time for transfer agreed YES NO

RF Ward Name:

Acceptance by Receiving Medical Practitioner YES NO

Date: _____ Time: _____

Receiving Medical Practitioner / Unit Name:

_____

Phone No & Pager: _____

Acceptance by RF Bed Coordinator: YES NO

Date: _____ Time: _____

Receiving Bed Coordinator Name:

_____

Phone No & Pager: _____

Patient Transport Provider Name:

Date & Time booked:

Form completed by: (name and position/designation)

Signature:

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