IN-HOUSE TRANSFER FORM

To Be Completed By Sending Unit Current Shift I_____ O_____
IV Credit_____
IV Site Checked_____

Date _____
Room Transferring From _____ Room Transferring To _____

Time _____ BP _____ T _____ P _____ R _____

RN ASSESSMENT (include patient's response to treatment given thus far) _____

(RN Signature)

Last PRN Med _____ Time _____ Report Given To _____ Time _____
O_2 _____ Monitor _____ Mode of Transfer Cart _____ W/C _____ Amb _____
Family / Significant Other (state name) _____

Nursing Supervisor notified (if transferring to a critical care area) _____

Physician notified (name) _____ Time _____

Ancillary departments notified Lab_____ Dietary _____ Pharmacy _____ X-ray_____ Admissions _____

Signature of transferring nurse _____ Time _____

TO BE COMPLETED BY SENDING & RECEIVING UNITS

	SENDING UNIT NURSE	RECEIVING UNIT NURSE
OLD CHART		
PARTIAL CHART		
KARDEX/CLASSIFICATION/ CARE PLANS/S.O.C.		
MEDICATION ADMINISTRATION RECORD		
MEDICATIONS		
CLOTHING		
ID BAND		
ADDRESSOGRAPH PLATE		

PERSONAL POSSESSIONS

	Safe	Bedside	Family
Money			
Jewelry			
Dentures Upper			
Lower			
Partial			
Glasses			
Contacts			
Hearing Aid			
Prosthesis (Type)			
Electrical Appliance			
Other Equipment			
Sending Unit Nurse's Initials		Receiving Unit Nurse's Initials	

DAILY LAB _____

REQUISITIONS SENT THROUGH _____

To Be Completed By Receiving Unit

TIME RECEIVED _____ BP _____ T _____ P _____ R _____

RN ASSESSMENT ON ARRIVAL _____

(RN Signature)

PATIENT ID

IN-HOUSE TRANSFER FORM

Out of Facility Transfer

Bulloch Memorial Hospital is required by Federal Law to provide any presenting patient with a medical screening examination to determine whethe
mergency medical condition exists and to provide necessary stabilizing care within its capabilities for emergency medical conditions withou
d to means or ability to pay. This hospital does participate in Medicare and Medicaid.

① PATIENT CONDITION

A ☐ There is no reasonable likelihood of deterioration from or during transport.

B ☐ The patient may be at risk for deterioration from or during transport.

Based upon my examination of the patient and the information available to me at time of transfer, I certify that the risks of transfer are outweighed by the benefits reasonably anticipated from proper care at the receiving facility.

② REASON FOR TRANSFER

A ☐ For equipment or services not available at this facility:(list)_____

B ☐ Patient-initiated request for transfer. Services are available here and offered to patient, who wishes of their own volition and request to be transferred.

C ☐ A legally responsible person acting on the patients behalf requests transfer.
Name_____
Relationship_____

③ RISKS OF TRANSFER

_____

_____

☐ All transfers have inherent risks of delays or accidents in transit, pain or discomfort upon movement and limited medical capacity of transport units that may limit available care in the event of a crisis.

④ BENEFITS OF TRANSFER

_____

_____

_____

⑤ MODE OF TRANSPORT

☐ ALS Ambulance
☐ BLS Ambulance
☐ Additional Personnel:
☐ Helicopter
☐ Fixed Wing Aircraft
☐ RN ☐ MD
☐ Respiratory Therapist

Service Contacted:_____ ETA:_____
By:_____ Time:_____

⑥ PATIENT CONSENT TO TRANSFER

I understand the risks and benefits of my transfer.
☐ I hereby CONSENT to transfer
☐ I hereby REFUSE transfer

Patient Signature or On Behalf of Patient Time

Witness Witness

⑦ HOSPITAL ACCEPTANCE

A Name of destination hospital:_____

B Accepted by:

_____
Name Time

_____Initials of person obtaining acceptance

C Accepting MD:

_____
Name Time

_____Initials of person obtaining acceptance

⑧ RELEASE OF MEDICAL RECORDS

I give consent to this hospital to release my entire medica records to the receiving facility, including all X-ray's and Laborator test results.

Patients Signature or On Behalf of Patient

⑨ PATIENT'S BELONGINGS INVENTORY

Patient's valuables/belongings inventory

☐ Sent with patient
☐ Placed in safe

⑩ DISCHARGE VITALS

DISCHARGE VITALS	TIME:
B/P:	Pulse:
Resp:	Temp:

Nurses Signature Date/Time