INTERHOSPITAL TRANSFER   Date: _____

PATIENT STICKER		

	REFERRING TEAM	RECEIVING TEAM
	HOSPITAL:	HOSPITAL:
	SPECIALTY:	SPECIALTY:
	CONSULTANT:	CONSULTANT:
	LOCATION:	LOCATION:
	TEL:	TEL:

WEIGHT _____

NOK _____

DIAGNOSIS: _____

INDICATION FOR TRANSFER: _____

TRANSFERRING TEAM: _____

TIME CRITICAL ☐   **DEPARTURE TIME** _____   **ARRIVAL TIME** _____

DOCUMENTATION ☐   **HANDOVER** ☐   **PATIENT ID BAND** ☐

SUMMARY OF EVENTS

PAST MEDICAL HISTORY

DRUG HISTORY

ALLERGIES   **ECR CHECKED** ☐

INTERVENTIONS

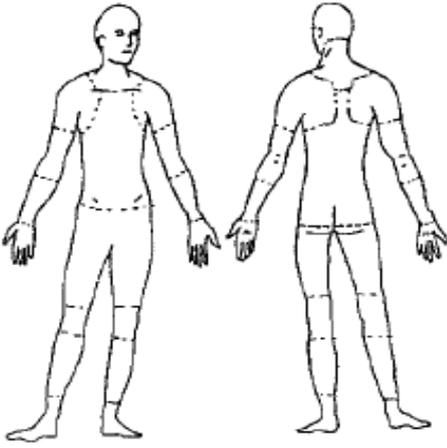**IMAGING**   **REPORTS ATTACHED** ☐

PLEASE PHOTOCOPY PRIOR TO DISCHARGE

INTERHOSPITAL TRANSFER   Date: _____

	CURRENT STATUS TIME:	PRE- DEPARTURE CHECKLIST TIME:
AIRWAY	SELF ☐ FACEMASK ☐ ETT ☐ TYPE SIZE GRADE VL/DL LENGTH AT TEETH	ETT SECURE ☐ LENGTH AT TEETH ☐ ETCO2 ☐ X-RAY (+CVC/ NGT) ☐ <u>C-SPINE</u> PRECAUTIONS ☐ AIRWAY EMERG BAG ☐

BREATHING	FIO2 SpO2
	RR
	SV ☐ IPPV ☐
	MODE Vt xRR
	PIP PEEP
	ABG pH HCO3
	      pCO2 BE
	      pO2 Lac
		AMBUBAG ☐
		MAP C ☐
		
		OXYGEN CALC ☐
		
		02 (L) = 2 X (MV+ BIAS FLOW) X DURATION
		TRANSFER IN MINS
		
		(OXYLOG 300 BIAS FLOW =0.5L/MIN)

CIRCULATION	HR RHYTHM BP (MAP) CRT CV SUPPORT	IV ACCESS ☐ CVC ☐ ART ☐ FLUSH BAG SALINE ☐ EMERGENCY DRUGS ☐ DEFIB PAD ON ☐
DISABILITY	GCS E M V PUPILS L R SEDATION BLOOD GLUCOSE	PUPILS CHECKED ☐ SEDATION ☐ NEUROPROTECTION ☐ CURARISED ☐
EXPOSURE	TEMP RASH SECONDARY SURVEY	TEMP MONITORING ☐ WARMING ☐

FLUIDS	IN FLUIDS
	        BLOOD
	OUT URINE
	        DRAIN
		FLUID ☐
		BLOOD ☐
		CATHETER ☐

GASTROENTEROLOGY	FASTING ABDOMEN	NGT ☐
HAEMATOLOGY / BIOCHEM	Na Hb K Plt Ur PT Cr APTT	XM/ G+H ☐
INFECTIVE STATUS	ANTIBIOTICS TIME: + MICRO CULTURES SENT ☐	INFECT CONTROL RISK ☐ Covid 19 Status _____ PCR tests X 2

Observation Chart –for use during transfer									
Time: HRS									

PLEASE PHOTOCOPY PRIOR TO DISCHARGE

INTERHOSPITAL TRANSFER

Date: _____

Mins								
Drug infusions								
Ventilator mode								
FIO2								
Tidal Volume								
Respiratory rate								
PEEP								
Peak insp pressure								
Minute Volume								
ETCO2								
SPo2								
Blood pressure								
Heart rate								
Heart rhythm								
Pupil Size/Reaction L								
Pupil Size/Reaction R								

Fluids/ drug boluses / Lines

Escorting Personnel

Nurse Name:………………………………Grade:………Doctor Name:………………………………………Grade:………

PLEASE PHOTOCOPY PRIOR TO DISCHARGE