FOR MEDICAL RECORD USE ONLY

• MEDICAL RECORD COPY •

South Eastern Sydney Illawarra Area Health Service

PATIENT TRANSFER SUMMARY

HOSP ID MRN
SURNAME
OTHER NAMES
DOB SEX AMO

MRN BAR CODE

AFFIX PATIENT IDENTIFICATION LABEL HERE

- **To be completed for all interdepartmental patient transfers, including transfers for procedures not requiring consent, e.g. x-ray.**
- **For procedures requiring consent, complete only the Procedure Checklist.**

TRANSFER DETAILS

Transfer Date:..... Time: .....
Transfer From:..... To:.....
Diagnosis:.....
General Condition: .....

MANAGEMENT / INTERVENTIONS / ASSESSMENTS

(Document only where appropriate or write N/A if not applicable)

Glasgow Coma Score:	Pain Management: Specify:.....
O_2 Therapy: ☐ Yes ☐ No Specify:.....	Diabetic: ☐ Yes ☐ No Blood Sugar Level:..... Time:.....
Fluid Balance Chart: ☐ Yes ☐ No ☐ IV Therapy ☐ IV Access	Incontinent: ☐ Yes ☐ No Specify: ☐ Bowels ☐ Urine Urinary Catheter: ☐ Yes ☐ No Specify: IDC / SPC / Other
Dietary Requirements: Specify Type:..... ☐ NBM	Multi-Resistant Organism and/or Infection Alert: ☐ No ☐ Yes Type / Site:..... Biohazard Alert:.....
Mobility Issues:..... Falls Risk Score: ..... Date:..... ☐ N/A	Wound Chart: ☐ Yes ☐ No Pressure Ulcer Risk Assessment Waterlow Score: ..... ☐ N/A

GENERAL

	YES	NO	ADDITIONAL COMMENTS
Patient ID Band	☐	☐	
Alert Bands	☐	☐	
e.g. red for allergies, purple for cytotoxicity			
Medication Charts	☐	☐	
Observation Charts	☐	☐	
Dentures	☐	☐	
Prosthesis	☐	☐	
Communication Deficit	☐	☐	
e.g. hearing, speaking			
Interpreter required	☐	☐	
Personal property / valuables	☐	☐	
Relatives informed	☐	☐	
Refer to clinical notes			
X-Rays / scans	☐	☐	
Old Notes	☐	☐	
Critical Orders	☐	☐	

SPECIAL INSTRUCTIONS / OTHER RELEVANT INFORMATION

Name of nurse transferring: _____
Signature: _____
Designation: _____

Name of nurse receiving: _____
Signature: _____
Designation: _____

BINDING MARGIN - NO WRITING

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