Transfer Checklist

Hospital Communications	
Date and Time:	
Patient Name/Age: DOB Identification Bracelet applied to _____ (location of band)	
Sex/ WT (in kg) Height in cm Head circumference if less than 2 years of age:	
Chief Complaint:	
Referring MD:	Accepting Facility: Accepting MD:
Consent: **AMPLE History:** **A:** Allergies **M:** Medications **P:** Past medical History **L:** last meal **E:** Events leading up to injury	
CHECKLIST	
☐ **Working Diagnoses**	
☐ Interventions/Treatments Thus far:	
☐ Physical Findings and Assessment:	
☐ Airway Assessment (circle any patient presenting symptoms)	Normal-breath sounds clear and equal Noisy breathing Retractions Drooling Tripoding Intubated size, position
☐ Breathing (circle any patient presenting symptoms)	O2 requirement- Nasal cannula or mask ___L Increased WOB Altered LOC
☐ Circulation (circle any patient presenting symptoms)	Dysrhythmias Poor perfusion Cap Refill _____sec Vascular Access- _____(site/size)
☐ Disability	GCS E: _____ V: _____ M: _____ = ____ Increased ICP (pupils, posturing) Seizure Activity Fontanels- soft___ bulging___ Non applicable __
☐ Exposure (any precautions/isolation)	Rash Wounds Deformity
☐ Abnormal Lab findings	

☐ Radiological findings	
☐ Mode of transportation (to be matched with patient acuity and care needs during transport)	BLS ALS Specialty Team Air vs Ground Private Car
☐ Specialty equipment to accompany patient on transfer:	List all specialty equipment/supplies to accompany patient: i.e. blood products/medications/warming device
☐ Documentation accompanying patient	Medical Record Yes____ No____ Radiographic disk, films or copies Yes ____ No____ Lab Results Yes____ No____ Consent to transfer Yes____ No ____ Transfer Note Yes ___ No ____
☐ Parent Guardian Considerations	Consent to transfer obtained Yes ___No___ Plan for transfer of patient belongings Yes___ No ____ Referral institution information including directions and accepting physician name provided to family Yes ____ No____
☐ Vital signs prior to Departure including: Respiratory rate ____Heart rate ____ Blood Pressure _____ and Temperature_____ Oxygen Sat_____	
☐ Departure Time:	
Name and number of contact person if additional information needed: _____	
Transferring Nurse Signature:	
Transferring Physician Signature:	

Adaptation of tool from:
Golden Hour The Handbook of Advanced Pediatric Life Support
3rd edition, 2011
Nichols, Yaster, Scleien, Padias