ATTACHMENT 13: PEDIATRIC PATIENT TRANSFER FORM

Purpose: Provide a method of communicating medical and treatment information during a disaster when pediatric patients are being transferred to another health care facility (e.g., pediatric specialty care centers).

Instructions: This form should be completed to the best of the provider's ability given the care that has been provided on every patient transferred to another health care facility. This form should be completed prior to transfer. The original form will accompany the patient while a copy of the form should remain with the patient's medical record at the transferring health care facility.

Note: All information within this form is confidential and should not be shared except with those assisting in the care of the patient.

Incident name		Date	Time
Form completed by	Title		
Patient Name (Last, First)	DOB		Sex □ Male □ Female
Tracking Number (assigned by initial health care facility)	Age Years Months □ Estimated		
Parent/Guardian present □ No □ Yes If yes, provide the following information: Name Phone Custody/legal status Documentation provided □ No □ Yes	Is information about parent/guardian known? □ No □ Yes If yes, provide the following information: Name Phone Are the whereabouts of the parent/guardian currently known? □ No □ Yes Efforts to contact		
Interpreter needed? □ No □ Yes Language	Primary care provider notified? □ No □ Yes Phone		

INITIAL STATUS

Transferring health care facility Unit at hospital Full Address	Transferring physician
	Transferring physician specialty □ ED □ Pediatrician □ Family Practice □ Neonatologist □ Obstetrician □ Other (list)
Phone	Transferring physician/facility contact's phone
Preliminary Diagnosis	Reason for transfer

Acuity Level □ Stable/Non-emergent □ Stable/Emergent □ Unstable/Emergent

Requested services/specialty □ ED □ Trauma □ PICU □ NICU □ Burn □ In-patient services □ Other specialty services (list): _____

PATIENT HISTORY

Weight	**Allergies (list)**	**Home medications (list)**
kg □ actual □ estimated	□ NKDA □ Unknown	□ None □ Unknown □ See attached medication reconciliation form

Relevant Medical/Surgical History (list) □ See attached

CLINICAL ASSESSMENT AND TREATMENTS

Vital signs (time)	T	HR	RR	BP	SaO2
(initial)					
(most recent)					

Intake/Output (time)	INTAKE	OUTPUT

Vascular Access □ Arterial □ IO □ PICC □ PIV □ UVC
□ Indwelling Venous Catheter □ Central Venous Line
Site
Fluid Type Rate
Bolus? □ No □ Yes Type
Total Volume Time given

Physical Findings

FORM CONTINUES ON PAGE 2

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Current Medications: ☐ See attached	**X-Ray/CT/MRI/Ultrasound Results** ☐ See attached

Blood Gas ☐ See attached

Time	Site	pH	pCO_2	pO_2	HCO_3	BD/BE

Labs ☐ See attached

Other (include critical lab values):

Airway

Intubated ☐No ☐Yes
ETT/TR Size Depth
Vent settings
CXR ☐ No ☐ Yes

O_2 Mask ☐ No ☐Yes
Nasal Cannula ☐No ☐Yes
O_2 Liters/Min
Bi-PAP/CPAP ☐No ☐Yes
Settings

	+	-	Pending	Isolation
Flu	☐	☐		
RSV	☐	☐		
MRSA	☐	☐		
Cough	☐	☐		

Other Treatments

Treatment Summary

TRANSPORT NEEDS

Type of transport service needed ☐ BLS ☐ ALS ☐ Critical Care ☐ Ground ☐ Air ☐ Other	Type of transport service available at transferring hospital? ☐ No ☐ Yes
Name of transport provider used to transport patient	Phone number of transport provider

Equipment needed for transport oxygen ventilator C-PAP cardiac monitor IV pump invasive monitoring spine immobilization restraints isolette car seat Other (list)

MEDICAL MANAGEMENT PROVIDED BY PCMS

Management Discussion/Recommendations ☐ Telemedicine Capabilities Used

RECEIVING HOSPITAL INFORMATION

Receiving hospital Address Bed assignment Phone	Receiving physician Specialty ED Pediatrician Family Practice ☐ Neonatologist Obstetrician Other (list) _____ Receiving physician phone

Assignment Date	Assignment Time	Person contacted at transferring hospital

ADDITIONAL NOTES