|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Service | | MR# | | | | DOB | | | | | Age | | | | Gender | |
| Time of Arrival | | | | Time at Transfer | | | | | | | Total time in ER (hours and minutes) | | | | | |
| Arrival Mode POV EMS Other | | | | | | | | | | | | | | | | |
| Chief Complaint | | | | | | | | Diagnosis | | | | | | | | |
| Sending MD | | | | | | | | Receiving MD | | | | | | | | |
| Receiving facility Gen Peds PIMC PICU ER | | | | | | | | | | | | | | | | |
| Mode of transfer POV EMS Flight Other | | | | | | | | | | | | | | | | |
| Level of provider BLS ALS CCT | | | | | | | | | | | | | | | | |
| Accompanied by MD RN RT | | | | | | | | | | | | | | | | |
| Transfer Details | | | | | | | | | | | | | | | | |
| Reason for Transfer   1. Need for higher level of care \_\_\_\_\_ 2. Need for specialty care\_\_\_\_\_ 3. Family/MD request \_\_\_\_\_ 4. Insurance \_\_\_\_\_ | | | | | | | | | 1. Other (explain) | | | | | | | |
|  | | | | | | | Yes | | No | NA | | Comments | | | | |
| Private MD Notified | | | | | | |  | |  |  | |  | | | | |
| Consultation with tertiary care center | | | | | | |  | |  |  | |  | | | | |
| Transfer documentation complete | | | | | | |  | |  |  | |  | | | | |
| Condition of patient at time of transfer documented | | | | | | |  | |  |  | |  | | | | |
| Transfer of patient belongings | | | | | | |  | |  |  | |  | | | | |
| Referral information provided to parent/guardian | | | | | | |  | |  |  | |  | | | | |
| Vital Signs (minimally initial and discharge) | | | | | | | | | | | | | | | | |
| Date/Time |  | |  | |  | | | |  | | | |  |  | |  |
| Temp |  | |  | |  | | | |  | | | |  |  | |  |
| HR |  | |  | |  | | | |  | | | |  |  | |  |
| Rhythm |  | |  | |  | | | |  | | | |  |  | |  |
| RR |  | |  | |  | | | |  | | | |  |  | |  |
| BP |  | |  | |  | | | |  | | | |  |  | |  |
| SPO2 |  | |  | |  | | | |  | | | |  |  | |  |
| ETCO2 |  | |  | |  | | | |  | | | |  |  | |  |
| Cap Refill |  | |  | |  | | | |  | | | |  |  | |  |
| Glucose |  | |  | |  | | | |  | | | |  |  | |  |
| AVPU |  | |  | |  | | | |  | | | |  |  | |  |
| Interventions in place on transfer | | | | | | | | | | | | | | | | |
| Respiratory | | | Circulatory | | | | | | Musculoskeletal | | | | | Other | | |
| O2 \_\_\_\_L via BVM/Mask/NC | | | IV | | | | | | Spinal motion restriction | | | | | Warming/Cooling device | | |
| Intubated | | | IO | | | | | | Extremity Splint | | | | |
| Tracheostomy | | | Central Line | | | | | |  | | | | |
| Cricothyrotomy | | | Fluids \_\_\_\_\_mL Warmed Y/N | | | | | |  | | | | |
|  | | | Blood \_\_\_\_\_mL Warmed Y/N | | | | | |  | | | | |
| Follow up needed/Other findings  Audit completed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |