EMERGENCY – INTER-AGENCY REFERRAL AND TRANSIT RECORD

Date/Time of Referral:

Disposition of belongings:

Reports with patient: ☐ No ☐ Yes *(If yes, check boxes)*

☐ X-ray *(type)* ☐ Lab
☐ ECG ☐ Monitor Strips
☐ Other: *(list)* ☐ Initial Assessment
☐ Physician Notes ☐ Outpatient Record
Consult/History/Other

Identification Arm Band on - ☐ NA ☐ Yes ☐ No *(why)*

Health Care Directives In Place ☐ Yes ☐ No *If yes, attach a copy*.

Infection Control ☐ Precautions required *(check and describe)*
☐ C.Diff ☐ Hepatitis ☐ Other:
ARO Screening: ☐ No ☐ Yes *(if yes, check and describe including date and results)* ☐ VRE ☐ MRSA ☐ Other:

☐ **Receiving Agency notified**
☐ **EMS notified**
☐ **Public Health notified**

Date of last TB test ☐ Negative ☐ Positive ☐ Not Known
Immunization History: ☐ Known ☐ Not Known Type/dates:

Key Contact – Name/Relationship:

Notified: ☐ Yes ☐ No

TEL #: H: **W:** **C:**

Allergies: *(list and describe reactions)* ☐ None Known

☐ Copy of Facility-specific Allergy/Intolerance Record attached

Personal belongings with patient: ☐ Yes ☐ No *(If no, where?)*
Hearing Aid(es) ☐ Rt ☐ Lt ☐ Glasses ☐ Contact lenses Denture(s) ☐ Upper ☐ Lower ☐ Partial
☐ Other belongings *(list)*

	Hospital	**Location**	**Physician**
Referred from:			
Referred to:			

Hospital Notified: ☐ No ☐ Yes **Transfer Confirmed** ☐ No ☐ Yes **Transfer Completed:** Date and Time:
Report Given ☐ No ☐ Yes Receiving Nurse Name: **EMS Report** ☐ No ☐ Yes Name of EMS:
Accompanying Equipment :(ID #) ☐ No ☐ Yes*(list)* **Return Equipment to**:

Comments: **ID:**

PHYSICIAN'S NOTES AND COVERING TRANSIT ORDERS - To be filled out by physician

Type of Transport Required: ☐ Road Ambulance ☐ Fixed Wing/STARS ☐ Peds/NICU transport ☐ Other
Personnel Required for Transport: ☐ BLS required ☐ ACLS required

Diagnosis:

Reason for Transfer:

Present Condition:

Treatment(s) Completed:

Dressings ☐ Yes ☐ No
Packing ☐ Yes ☐ No *(if Yes, describe including count)*

Physician's Orders: *(if inadequate space, send copy of Dr. order sheet)*

IV AND FLUID RECORD

Date	Time	Needle Size, Type and Site	Solution and Amount	Additives	Rate	Amount Absorbed	IV #	Comments	ID

Oral Intake*(mLs)*: **IV***(mLs)*: **Output***(mLs)*:

Transit Signature: **Receiving Signature:** **Date/Time:**

Original remains at receiving hospital ***Copy returned to referring hospital***

3sHealth, NISS Copyright. Not to be reproduced in any manner.