EMERGENCY – INTER-AGENCY REFERRAL AND TRANSIT RECORD

Date/Time of Referral:

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

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

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:

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

☐ Receiving Agency notified
☐ EMS notified
☐ Public Health notified

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: **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: ☐ Physician ☐ RN ☐ 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: (*Add appropriate 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 to receiving hospital ***Copy to referring hospital***