

# DELAWARE INTERAGENCY PATIENT TRANSFER FORM - EMERGENT

Patient Name		Date of Birth	Last 4 Digits of SSN	Gender Preference	M	F
Transferring Facility		Contact Number	Primary Nurse		Contact Number	
Reason & Time for Transfer						
Referring Medical Practitioner		Contact Number		<b><u>TRANSFER PROTOCOL (as applicable)</u></b> 1. Obtain order and complete this form 2. Contact Receiving Facility 3. Provide report to Receiving Facility 4. Send this form & related available documents with transport team to facility **  <b><u>**Documents to send to Receiving Facility</u></b> • Face sheet, Past Medical History, Problem List • Current MAT or Medication Reconciliation • H&P, Recent Progress Notes, DC Summary • Recent Lab & Imaging Results		
Attending Medical Practitioner		Contact Number				
Responsible Party/POA		Contact Number				
Code Status - ATTACH RELATED DOCUMENTS						
<input type="checkbox"/> Full Resuscitation <input type="checkbox"/> DMOST Orders <input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> Comfort measures only						
Lines/Tubes/Drains (Check if YES, indicate placement date and location)			Special Precautions			
Intubated? <input type="checkbox"/> Y <input type="checkbox"/> N      Foley? <input type="checkbox"/> Y <input type="checkbox"/> N IV Central Line    PICC    Port Location/Date:  Chest Tube    Feeding Tube    Drain Location/Date:			MRSA    Date: VRE    Date: C-Diff    Date: CRE    Date: Rash    Date: Comments:			
Allergies/Reactions (attach list)			Fall Risk/History:			
Pain Level at Transfer (1-10)			Skin Breakdown:			
Blood Transfusion <input type="checkbox"/> Accepts <input type="checkbox"/> Refuses			Aspiration:			
Baseline Mental Status - Check all that apply						
<input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Agitated <input type="checkbox"/> Somnolent <input type="checkbox"/> Unresponsive <input type="checkbox"/> Confused <input type="checkbox"/> Non-Verbal						
Baseline Mobility <input type="checkbox"/> Independent/Ambulatory <input type="checkbox"/> Partial Assist <input type="checkbox"/> Full Assist						
Ambulatory Aids: <input type="checkbox"/> Independent <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair						
Form Completed By:				Date & Time		
Transfer Facility SECURE HIPAA compliant Fax Line Number:						

**Transferring Provider Capabilities IN THE NEXT 24 HOURS:**

IV:

Fluids     Antibiotics     Diuretics

Transfer back with IV access if placed

Laboratory testing tomorrow

Image testing tomorrow

Will Physician/Practitioner be able to see patient in the facility TOMORROW?

Yes     Uncertain     No

## **Delaware EMERGENCY DEPARTMENT Contact Information**

### **Bayhealth Kent Campus ED**

P: 302-744-7121

F: 302-735-3256

### **Bayhealth Sussex Campus ED**

P: 302-430-5720

F: 302-430-5515

### **Bayhealth Smryna ED**

P: 302-659-2190

F: 302-659-1937

### **Beebe Healthcare ED**

P: 302-645-3554

F: 302-645-3407

### **Christiana Hospital ED**

P: 302-733-6806/1700

F: 302-733-1089

### **Wilmington Hospital ED**

P: 302-320-2623/4182

F: 302-320-4188

### **Nanticoke Health System ED**

P: (302)396-3785/629-6611x2252

F: (302)628-6383

### **Saint Francis Hospital ED**

Phone: 302-421-4333

Fax: 302-421-4858