MEMORANDUM OF TRANSFER

SECTION A (To Be Filled Out at Transferring Hospital)

1. Name of Transferring Hospital:_____
   Address: _____
   _____Phone #_____

2. Patient Information (If Known):
   Patient's Full Name: _____
   Address: _____
   Phone Number: _____ Sex: ☐ Male ☐ Female
   Age: _____DOB: _____National Origin: _____
   ☐ Physical Disability ☐ Demographic/Face Sheet/Insurance Info Attached

3. Next of Kin (If Known): _____
   Address: _____
   _____
   Phone Number: _____
   Next of Kin notified? (_____) Yes (_____) No

4. Date of Arrival: ____ / ____ / ____ Time: _____

5. Diagnosis: _____
   Isolation status: _____

6. Initial contact with the receiving hospital administration:
   Date: ____ / ____ / ____ Time: _____
   Name of contact person at receiving hospital:
   _____

7. Receiving physician secured by transferring physician:
   Date: ____ / ____ / ____ Time: _____
   Name of receiving physician: _____

8. Reason for Transfer: ☐ Higher Level of Care ☐ Other
   _____

9. Transferring physician's signature or signature of hospital staff acting under physician's orders: _____
   Printed Name of transferring physician:
   Phone Number: (_____) _____Address: _____
   _____

10. Accepting hospital secured by transferring hospital:
    Date: ____ / ____ / ____ Time: _____
    Name of receiving hospital administration person:
    _____

11. Report given by transferring hospital nurse:
    Signature: _____
    Title: _____ Time: _____

12. Pertinent Nursing Findings: V/S: B/P___P___R___ Temp___O2 Sat___
    Lines: ☐ O2 per _____ ☐ IV Fluids _____ Rate: _____ ☐ _Intubated/Vent
    ☐ Urinary Cath Other: _____
    LOC/Sensory Status: ☐ None ☐ Mental ☐ Vision ☐ Hearing ☐ Speech
    ☐ Sensation ☐ Immobilizer
    Oral Restrictions: ☐ None ☐ NPO ☐ Other: _____Allergies ☐ No ☐ Yes
    Immobilization: ☐ None ☐ Cast ☐ Splint ☐ Traction ☐ Other: _____

13. Type of transfer vehicle and company used: _____
    Equipment/Personnel needed: _____

14. Facility transported to: _____
    City _____Date: _____ Time: _____

15. Other Attachments for Care/Results from Transferring Facility:
    ☐ Radiology ☐ Nursing Notes ☐ Lab Reports ☐ H&P ☐ Progress Notes
    ☐ MAR (meds in ED) ☐ List of Home Meds

SECTION B (To Be Filled Out at Receiving Hospital)

1. Name of Receiving Hospital: _____
   _____
   Address: _____
   _____
   Phone Number: (_____) _____

2. Date of Arrival: ____ / ____ / ____ Time: _____

3. Receiving Hospital Administration Signature:
   _____
   Title: _____ Date: ____ / ____ / ____

4. Receiving physician who assumed responsibility for the patient:
   Date: ____ / ____ / ____ Time: _____

Receiving Physician's signature:
_____
Name: _____
Address: _____
_____
Phone Number: (_____) _____

5. If response to the transfer request was delayed beyond thirty (30) minutes, document the reason for the delay, including any agreed time extensions. Use additional sheet, if necessary. _____
   _____
   _____
   _____
   _____
   _____