# Manitoba Information Transfer Referral Form
# Guidelines for Completion

**Effective communication is a key component of Quality Patient Care. Information Transfer is also a Required Organizational Practice (ROP) as directed by Accreditation Canada. This form should be completed each time a patient transfers from one setting of care to another setting of care, regardless of reason for transfer and includes use for all ambulatory/out-patient visits and in-patient transfers.**

| Data Required | Completion Instructions | Source |
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| **Sending Facility/Program Required Information** | | |
| Transfer From | Enter referring facility, agency and/or department with location and phone number | Recorder |
| Transfer To | Enter receiving facility, agency and/or department with location (e.g. unit name) if known and phone number | Recorder |
| Accepting Physician/ Practitioner | Enter name of Physician/Practitioner who has accepted care for the patient. Enter name of other physicians/specialists who have been involved in the care/transfer of the patient | Chart |
| Sending Physician/ Practitioner | Enter name of Physician/Practitioner who is currently providing care for the patient | Chart |
| Nurse to Nurse Report Given | Verbal report should be given. Check “Yes” or “No” | Recorder |
| Date and Time of Transfer | Enter DD/MMM/YYYY of transfer/referral and time | Recorder |
| Organ Donation | Check “Yes”, “No”, or “Unknown” | Chart or Patient/Family |
| **Patient Identification** | | |
| Addressograph Patient ID applied | Addressograph form on top right hand corner of form if available at referring facility | Patient ID card |
| Surname | Enter patient’s surname, if **NO** addressograph available. | Chart |
| Given Name | Enter patient’s given name if **NO** addressograph available. Enter patient’s given name on top of page 2 if form is not double sided. | Chart |
| Date of Birth | Enter patient’s birth date if **No** addressograph available. DD/MMM/YYYY | Chart |
| Sex | Enter patient’s sex in **No** addressograph available. Male or Female | Chart/observation |
| Health Record Number | Enter patient’s health record number if **No** addressograph available. Facility health record number (patient’s chart number) | Chart |
| Provincial Health Care Number | Enter patient’s MB Health number if **NO** addressograph available | Chart or MB Health card |
| PHIN | Enter patient’s 9 digit Personal Health Identification Number if **NO** addressograph.<br>Enter patient’s 9 digit Personal Health Identification Number on top of page 2 if form is not double sided. | Chart or MB Health card |
| Patient ID Applied | Check to ensure patient has ID band affixed and that it is legible. Use 2 patient identifiers to ensure correct ID band is applied to the patient. | |

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| **CARE Alerts** | | |
| Allergies or Drug Reactions | List any known allergies or drug reactions for patient. **If no known allergies, check box.** | Chart or Kardex |
| Infection Control Precautions | | |
| Do you have an outbreak in your facility or on your ward? | Check the "Yes or No" box. If "Yes" identify type of outbreak on the "Specify" line | Chart or Infection Control Notices for facility/ward |
| Infection Prevention & Control Precautions | Check the box(es) for type of precautions required. If "Other" type of precaution identify on the "Other" line | Chart/Kardex |
| Antimicrobial Resistant Organism Status | MRSA Positive check "Yes or No"<br>MRSA Suspect check "Yes or No"<br>MRSA Previous Positive check "Yes or No" | Chart/Kardex |
| CPE Pos (Carbapenemase Producing Enterobacteriaceae) | CPE Positive check "Yes or No"<br>CPE Suspect check "Yes or No"<br>If "Other" type of precaution identify on the "Specify" line | Chart/Kardex |
| **Health Directives/Advanced Care Plans and Safety** | | |
| Health Care Directive | Check the box as "Yes or No". | Chart/Health Care Directive form |
| Advanced Care Plan Status: | Check box as applicable | Chart/Advanced Care Plan Status form |
| Violence Prevention Program Alert | Check the box "Active Alert" or "No Alert". If Active Alert, affix the Violence Risk sticker or stamp in the box to the right (∞purple/violet infinity symbol) | Chart/Violence Risk Assessment form |
| At Risk for Falls | Check the box as "Yes or No" | Chart/Falls Assessment form |
| Behaviour | Check box if applicable for "Agitation", "Verbal Aggression" or "Physical Aggression"<br>If any observed behavioural concerns document in the "Describe Observed Behaviour" lines | Chart |
| Security Issues/Visitor Restriction | Check box as "Yes or No". If Yes, document on the "Comments" line | Chart |
| Patient Held Under Mental Health Act - Form Number/Patient Information | Check box as "Yes or No".<br>Provide the type of Mental Health Form. Check the box "Yes or No" if the patient is aware | Chart |
| **Patient Demographics and Contact Information** | | |
| Patient's Address and Phone Number | Primary residence and home and/or cell number | Chart |
| Band & Treaty # | Enter patient's Band name and Treaty number/or 10 digit ID number, if known | Chart or Treaty Card |
| Private Insurance Provider and Policy Number | Enter patient's private insurance carrier and policy number e.g. Blue Cross, Group Life, etc. | Patient's insurance card or chart |
| Next of Kin | Enter next of kin or guardian's name, relationship and contact numbers | Chart or Kardex |

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| Notified of Transfer | Check box as "Yes or No" for Next of Kin Public Trustee, Power of Attorney, or Health Care Proxy. If unable to contact any, document attempts. | Chart/Kardex |
| Public Trustee/Power of Attorney, Health Care Proxy | Check "Yes or No" if patient is under Public Trustee/Power of Attorney or Health Care Proxy. A Proxy is considered to be a Guardian or substitute decision maker. Enter name and phone number where indicated. | Chart |
| Languages Spoken/Understood | Enter patients first language followed by any other languages that may be spoken/understood | Chart |
| Interpreter Required | Check "Yes or No" in box | Chart |
| **Primary Diagnosis and Co-Morbidities** | | |
| Primary Diagnosis and Co-Morbidities | Enter diagnosis and any co-morbidities, (i.e. Diabetic with Cardiovascular disease and Hypertension) | Chart |
| Reason for Transfer/Referral | Why is the patient being transferred (i.e. diabetic leg ulcer, not responding to treatments, consult with surgery for possible amputation) | Chart |
| **Supporting Documentation** | | |
| Photocopies Enclosed | Check any photocopies that will be forwarded with patient. DO NOT SEND ORIGINALS. Can include assessments, discharge summaries, consults, results, care plans, medication administration records, etc. Write in any other photocopies enclosed that are not identified | Chart |
| **Page 2: Write Patient's Name and PHIN Number at Top of Page in Form is NOT Double Sided** | | |
| **Special Considerations** | | |
| Oxygen | If applicable, check the box and "Specify" flow rate and administration device | Chart |
| IV/CVAD's | If applicable, check the box and specify solution, flow rate, device and any other pertinent information related to IV/CVAD | Chart |
| Dressings/Sutures/Drains | If applicable, check the box and specify location, status, any concerns | Chart |
| Wounds | If applicable, check the box and specify location, status, including staging and any concerns<br>If wound exists and is Stage III or greater, complete section on "Reported as CI" and indicate "Yes or No" | Chart |
| Tube Feeds/Flushes | If applicable, check the box and specify type of feeding solution, continuous or intermittent, time of last feeding, etc. | Chart |
| Other | If applicable, check the box and specify | Chart |
| **Level of Function (At Time of Transfer)** | | |
| Cognition | Check box for "Intact or Impaired" | Chart |
| Follows Directions | Check box as "Yes or No" | Chart/Kardex |
| MMSE SCORE | Mini Mental Status Exam – enter score and date last completed (DD/MMM/YYYY) | Chart |

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| MOCA SCORE | Montreal Cognitive Assessment – enter score and date last completed (DD/MMM/YYYY) | Chart |
| Safety Restraints Required | Specify type of safety restraint(s) required and reason | Chart |
| Ambulation | Check box as “Independent” or complete specifics for “Weight Bearing Status” | Chart |
| Mobility Equipment | Check box as applicable or if “other” specify type of equipment required | Chart |
| Transfer Status | Check type of assistance required to transfer as applicable | Chart |
| Dress | Check status as applicable | Chart |
| Hygiene | Check status as applicable | Chart |
| Feeding | Check status as applicable. Note Date/Time of last oral intake (DD/MMM/YYYY) | Chart |
| Dysphagia | Check box as “Yes or No” | Chart |
| Diet/Nutrition Supplement | Specify diet and/or Nutrition Supplement<br>Note: Diet as Tolerated is not a valid diet status. | Chart |
| Patient Weight | Document in Kilograms | Chart |
| Bladder | Check status as applicable<br>Note Date/Time of Catheter Insertion and Removal (DD/MMM/YYYY) | Chart |
| Time of Last Voiding | Note time | Chart |
| Bowel | Check status as applicable<br>Note Date of last B.M. (DD/MMM/YYYY) | Chart |
| Vision | Check vision aides as applicable<br>Note if they are accompanying the patient | Chart |
| Hearing | Check hearing aids as applicable<br>Note if they are accompanying the patient | Chart |
| Dentures | Check dentures as applicable<br>Note if they are accompanying the patient | Chart |
| Prosthetics | Specify type of prosthetic<br>Note if prosthetic is accompanying the patient | Chart |
| Valuables | Check valuables as applicable<br>Note if valuables including clothing are accompanying the patient | Chart |
| Other | Specify any other valuables, aids or equipment that is accompanying the patient (i.e. personal wheelchair) | Chart |
| **Additional Comments/Information** | | |
| Additional Comments | This area can be used to capture any information that has not been collected in other areas or comment on any YES indications.<br>If plan is detailed, <u>indicate</u> and attach as separate sheet. | Chart |
| Follow Up Appointments | Indicate any follow up appoints the patient may have indicating where and when | Chart |

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| **Print the Name/Title of the Recorder and signature** | | |
| **Return Transfer and Discharge Information – (For Short Stays of Less than 24 Hours Only)** | | |
| Return Transfer and Discharge Information for Short Stays of less than 24 Hours | If a patient returns to the original referring site **within 24 hours**, then this section is to be completed by the discharging facility that the patient was transferred to for short - term care. Examples: Outpatient/Emergency visit from Personal Care Home or referral for specialty examination (ex. Diagnostics). **If length of stay is greater than 24 hours, initiate a new transfer/referral form** | Chart |
| Discharged From | Indicate the name of the facility and the name of the department/patient care area that the patient is being discharge from | Chart |
| Contact Phone Number | Indicate the phone number of the department/patient care area that the patient is being discharged from | Hospital telephone directory |
| Discharge Summary and Recommendations | **A discharge assessment summary is vital.** Please photocopy written entries in chart Complete all sections and provide photocopies of any information that is pertinent to communicate. Attach separate sheet for any information / instructions that cannot be captured in space provided. | Chart from Discharging facility or department (e.g. ER, Diagnostics. ClinDoc) |
| Follow Up Appointments | List any follow up appointments that may be required | Chart |
| Discharge Instructions | Provide a copy of written discharge instructions | Chart |
| Medication Reconciliation | Include<br>• Admission Medication Reconciliation<br>• Transfer Medication Reconciliation<br>• Current Medication Administration Record | Chart |
| Accompanying Medications | List any medication sent with the patient.<br>Note: Many rural facilities have limited after hours pharmacy services and may not have access to specialize drugs | Chart |
| Consultations | Include any consultation reports during the stay | Chart |
| Test Results | Include any Lab or Imaging reports during the stay | Chart |
| Patient Return to Facility/Department Communicated with | Report to sending facility. Indicate the name of the person contacted about the return transfer, their title, the date and the time (DD/MMM/YYYY) | Recorder |
| Discharge Facility Contact Information | Complete date, name, and title required in space provided | Recorder |
| Photocopies Enclosed | Check any photocopies that will be forwarded with patient. DO NOT SEND ORIGINALS. Can include assessments, discharge summaries, consults, results, care plans, medication administration records, etc. Write in any other photocopies enclosed that are not identified | Chart |
| Please send original Inter-facility Transfer form with the Patient and keep a photocopy of this form on the patient's Health Record. | | |