Manitoba Information Transfer Referral Form

COMPLETION RESPONSIBILITY OF SENDING FACILITY/PROGRAM

Transfer From *(Facility/Location/Phone #)*

Transfer To *(Facility/Location/Phone #)*

Name of Accepting Physician/Practitioner

Name of Sending Physician/Practitioner

Date and Time of Transfer

D D M M M Y Y Y Y 24 HOUR

Nurse to Nurse Report Given
☐ Yes ☐ No

Organ Donation
☐ Yes ☐ No ☐ Unknown

SURNAME:

GIVEN NAME:

DATE OF BIRTH:

GENDER:

HEALTH RECORD #:

PROV HC #:

PHIN:

☐ Patient ID Applied

CARE ALERTS

Allergies or Drug Reactions: ☐ No Known Allergies

Do you have a current outbreak in your facility or on your ward? ☐ Yes ☐ No Specify: _____

Infection Prevention and Control Precautions: ☐ Droplet ☐ Airborne ☐ Contact ☐ Droplet/Contact ☐ Airborne/Contact
☐ Other: _____

Antimicrobial Resistant Organism Status:
MRSA POSITIVE: . . . . . ☐ Yes ☐ No CPE POSITIVE: . . ☐ Yes ☐ No
MRSA SUSPECT: . . . . . ☐ Yes ☐ No CPE SUSPECT: . . ☐ Yes ☐ No
MRSA PREVIOUS POSITIVE: . . ☐ Yes ☐ No

Other Specify: _____

Health Care Directive:	Advance Care Plan Status:	Violence Prevention Program Alert:	
☐ Yes ☐ No	☐ Resuscitation ☐ Medical Care ☐ Comfort Care	☐ Active Alert ☐ No Alert	AFFIX STICKER HERE IF ACTIVE ALERT

At Risk for Falls: ☐ Yes ☐ No

BEHAVIOUR: ☐ Agitation ☐ Verbal Aggression ☐ Physical Aggression

Describe Observed Behaviours:

Security Issues/Visitor Restriction: ☐ Yes ☐ No

Comments:

MENTAL HEALTH ACT

Patient Held Under Mental Health Act? ☐ Yes ☐ No

Form Number _____ Patient Informed of Status ☐ Yes ☐ No

Patient Address and Phone #:

Band and Treaty #:

Private Insurance Provider & Policy #:

Next of Kin (Name, Relationship,):				Phone #	Notified of Transfer ☐ Yes ☐ No
Public Trustee ☐ Yes ☐ No		Name:			Notified of Transfer ☐ Yes ☐ No
Power of Attorney ☐ Yes ☐ No		Name:			Notified of Transfer ☐ Yes ☐ No
Healthcare Proxy ☐ Yes ☐ No		Name:			Notified of Transfer ☐ Yes ☐ No

Languages Spoken/Understood: Interpreter Required ☐ Yes ☐ No

Primary Diagnosis and Co-Morbidities:

Reason for Transfer/Referral:

Photocopies Enclosed *(if applicable)*

☐ ED Records	☐ Vital Signs Record	☐ Lab	☐ PT
☐ Physician Transfer Notes	☐ Advance Care Plan	☐ Imaging	☐ SLP
☐ Care Plan	☐ Health Care Directive	☐ Operative Records	☐ Social Work
☐ Admission Medication Reconciliation	☐ Transfer Medication Reconciliation	☐ Current Medication Administration Record	☐ Registered Dietician
☐ ARO Specimen Results	☐ OT	☐ Home Care	

☐ Other _____

LEGEND:
ARO - Antibiotic-resistant Organism
MRSA - Methacillin-resistant Staphylococcus aureus
CPE - Carbapenemase-producing Enterobacteriaceae
CVAD - Central Venous Access Device
MMSE - Mini-Mental State Examination
MOCA - Montreal Cognitive Assessment
ED - Emergency Department
OT - Occupational Therapy
PT - Physiotherapy
SLP - Speech-Language Pathology

Please send original with patient. Place photocopy of this form on Patient Health Record.

Name _____ PHIN |_|_|_|_|_|_|_|_|_|_|

SPECIAL CONSIDERATIONS:

☐ Oxygen Specify: _____

☐ IV/CVAD's Specify: _____

☐ Dressings/Sutures/Drains Specify: _____

☐ Wounds Specify: _____ Reported as Critical Incident: ☐ Yes ☐ No

☐ Tube Feeds/Flushes Specify: _____

☐ Others Specify: _____

COGNITION: ☐ Intact ☐ Impaired Follows Directions: ☐ Yes ☐ No

MMSE SCORE: _____ Date: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_| **MOCA SCORE:** _____ Date: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_|

Safety Restraint Requirement and Reason:

AMBULATION: ☐ Independent ☐ Weight Bearing Status _____

MOBILITY EQUIPMENT: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other

TRANSFER STATUS: ☐ Independent ☐ One Assist ☐ Two Assist ☐ Mechanical Lift

DRESS: ☐ Independent ☐ Partial Assist ☐ Dependent

HYGIENE: ☐ Independent ☐ Partial Assist ☐ Dependent

FEEDING: ☐ Independent ☐ Partial Assist ☐ Dependent **Date/Time of Last Oral Intake:** D D M M M Y Y Y Y |_|_|_|_|_|_|_|_| 24 HOUR |_|_|_|_|

DYSPHAGIA: ☐ Yes ☐ No

DIET/Nutrition Supplement Specify: Patient Weight (kg):

BLADDER: ☐ Continent ☐ Incontinent Date and Time Catheter Inserted: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_| 24 HOUR |_|_|_|_|

TIME OF LAST VOIDING: |_|_|_|_| hours Date and Time Catheter Removed: |_|_|_|_|_|_|_|_| |_|_|_|_|

BOWEL: ☐ Continent ☐ Incontinent Date of Last Bowel Movement |_|_|_|_|_|_|_|_|

VISION: ☐ Contact Lenses ☐ Glasses Accompanying Patient ☐ Yes ☐ No ☐ N/A

HEARING: ☐ Aids ☐ Right ☐ Left Accompanying Patient ☐ Yes ☐ No ☐ N/A

DENTURES: ☐ Upper ☐ Lower Accompanying Patient ☐ Yes ☐ No ☐ N/A

PROSTHETICS: Accompanying Patient ☐ Yes ☐ No ☐ N/A

VALUABLES: Sent with Patient ☐ Yes ☐ No Given to Family/Significant Other ☐ Yes ☐ No

Rings: ☐ Yes ☐ No Jewellery: ☐ Yes ☐ No Personal Clothing: ☐ Yes ☐ No Money/Wallet: ☐ Yes ☐ No

Other: _____

☐ Other (list):

ADDITIONAL COMMENTS: _____

FOLLOW UP APPOINTMENTS: _____

Recorder: _____ _____ Date: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_|

SIGNATURE PRINTED NAME AND DESIGNATION

*** * * RETURN TRANSFER AND DISCHARGE INFORMATION (FOR SHORT STAYS OF LESS THAN 24 HOURS ONLY) * * ***

Discharged From: _____ **Contact Phone Number:** |_|_|_|-|_|_|_|-|_|_|_|_|

FACILITY/LOCATION

DISCHARGE SUMMARY and RECOMMENDATIONS (Photocopies Enclosed):

☐ Relevant Documentation from ClinDoc (as applicable) ☐ Follow-Up Appointment List: _____

☐ Discharge Instructions _____

☐ ED Records	☐ Vital Signs Record	☐ Lab	☐ PT
☐ Physician Transfer Notes	☐ Advance Care Plan	☐ Imaging	☐ SLP
☐ Care Plan	☐ Health Care Directive	☐ Operative Records	☐ Social Work
☐ Admission Medication Reconciliation	☐ Transfer Medication Reconciliation	☐ Current Medication Administration Record	☐ Registered Dietician
☐ ARO Specimen Results	☐ OT	☐ Home Care	

☐ Other _____

☐ Patient Return to Facility/Department Communicated with: _____ Date/Time: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_| 24 HOUR |_|_|_|_|

NAME

Recorder: _____ _____ Date: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_|

SIGNATURE PRINTED NAME AND DESIGNATION

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