Southern Health Santé Sud

NURSE ESCORT INTERFACILITY TRANSFER RECORD

Indications for use: To record information received on patient's condition prior to transfer, for documentation during the interfacility transfer and that transfer of care occurred at the receiving facility. This form is to be used in conjunction with the *Manitoba Information Transfer Referral Form* (CLI.4110.PL.007.FORM.01).

Transfer from (sending facility):	Transfer to (receiving facility):
☐ Report received from:	Date & Time:

Airway	Breathing	Circulation	Deficits	Output
☐ Normal	O2 @ ________L/min.	Heart Rate:	GCS:	Time last void:
☐ Oral airway	SpO2:	Rhythm:		Amt last void:
☐ ETT #: _________	Resp. Rate & quality:		Muscle Strength:	Foley cath #:
@ Lip __________cm.		Pulse quality:		Chest tube #:

Intravenous Medications

Site #1:	Rate:	Solution:	Medication infusing:
Site #2:	Rate:	Solution:	Medication infusing:

Pre-transfer check list: ☐ Manitoba Information Transfer Referral Form and copies of relevant records enclosed. ☐ Equipment/Supplies packed

Medications needed for transport ☐ Yes ☐ No | ☐ Family Aware | ☐ ACP level:

If documentation requirements may exceed this form (page 1 and 2), take additional copies.

Date/ Time	BP	Temp	ST Seg-ment	P Radial/ Screen	RR	SpO_2	Pain (0-10)	Assessments/Interventions/Outcomes NB: Record ALL medications administered on the copy of the enclosed MAR	NURSE Initials
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					
	/			/					

Transfer of Care at Receiving Facility (Also on page 2 – Only complete 1 area)

Verbal report provided and care transferred to (print name):

Signature of Nurse accepting care: Date/Time:

Form is to be returned to original sending facility and filed within the Patient's Health Record.

Southern Health Santé Sud

NURSE ESCORT INTERFACILITY TRANSFER RECORD (continued)

Date/ Time	BP	Temp	ST Seg-ment	P Radial/ Screen	RR	SpO_2	Pain (0-10)	Assessments/Interventions/Outcomes NB: Record ALL medications administered on the copy of the enclosed MAR	NURSE Initials

Transfer of Care at Receiving Facility: (Also on page 1 – Only complete 1 area)

Verbal report provided and care transferred to (print name):

Signature of Nurse accepting care: Date/Time:

Form is to be returned to original sending facility and filed within the Patient's Health Record.