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Children's Health
Request for Patient Transfer

Date of Call: ____________________ (dd/mm/yyyy)   Time of Call: ____________ (hhmm)

TOA Taken By: ______________________________   TOA Given By: ______________________________

Sending Facility: ____________________   Sending Doctor: ____________________   Accepting Doctor: ____________________

Patient's Name: ______________________________   Age: ________   Sex: ________

Weight: ____________   Allergies: ______________________________   Assigned Room No.: __________

Isolation Status and Reason: ______________________________

Transportation: ☐ EMS   ☐ Spectrum   ☐ Patient Transport   ☐ Family

Who is accompanying / meeting child at SCS? ☐ Parents/Guardian: ____________________   ☐ Other: ____________

With Nurse? ☐ Yes   ☐ No

Presenting Problem / Diagnosis:

____

____

____

____

____

Vitals Last At: ________ hours

Temp: __________   HR: __________   RR: __________ SpO_2: __________   BP: __________   Cap Refill: __________

GCS: __________   Pupils: __________

Vascular Access? ☐ Yes   ☐ No   IV Solution: ______________________________   Rate: __________ mL/hr

IV Size: ____________________   Bolus: ______________________________

Imaging: ☐ CXR   ☐ US   ☐ Other: ______________________________

Lab Investigations: Abnormal Labs: ______________________________

Microbiology Specimens Collected: ☐ Blood Culture   ☐ Urine Culture   ☐ NPS   ☐ Other: ____________

Oxygen Required? ☐ Yes   ☐ No   If Yes, Type: ______________________________

Medications Administered in ED:

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Notes:

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Sending RN: ______________________________   Receiving RN: ______________________________

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REQ16

Not a Chart Copy

NH Process for Pediatric Consult Requests from GNG & WHS ED & UCCs

DRAFT-May 23,2017