IDENTIFY

Government of Western Australia
WA Country Health Service
Hospital

Inter Hospital Patient Transfer
ADULT/CHILD HANDOVER

Date Time

Surname	URN
Given Names	DOB
Address	Postcode / Gender

Medicare No. | Ambulance fund number | DVA colour and number

☐ AB ☐ TSI ☐ ABTSI | Primary language spoken | Interpreter required ☐ Yes ☐ No

Contact person/NOK | Contact No. | NFR status documented ☐ Yes ☐ No

Relationship | Aware of transfer ☐ Yes ☐ No | Organ donor ☐ known ☐ Unknown

SITUATION

Referring hospital contact person: *Name* | Contact number

Signature *Designation* | Usual GP/Contact No.

Principle diagnosis/problem	Other diagnoses/problems

Reason for transfer

OBSERVATIONS

AIRWAY	BREATHING	COLOUR	CIRCULATION SKIN	PULSE	BEHAVIOURAL
☐ patent	☐ unremarkable	☐ unremarkable	☐ unremarkable	☐ unremarkable	☐ Harm to self
☐ compromised	☐ shallow	☐ pale	☐ warm / hot	☐ regular	☐ Harm to others
☐ ventilated	☐ deep	☐ flushed	☐ cool / cold	☐ irregular	☐ Requires physical restraint
	☐ rapid	☐ mottled	☐ dry	☐ slow	
	☐ slow	☐ cyanotic	☐ moist / clammy	☐ rapid	Glascow Coma Score
	☐ laboured			☐ strong	
	☐ asymmetrical	C-SPINE		☐ weak	Usual conscious state *(if known)*
	☐ audible wheeze	☐ immobilised		☐ not palpable	

Airway management plan

Airway compromise relayed to transport provider ☐ Yes *(Time)* ☐ No Outcome;

Vital signs *time:*	Temp.	Pulse	Resp rate	B.P.	SpO_2	☐ O_2 rate/device	Pain Score

☐ Intravenous (IV) access *(gauge, site, insertion time/date)* ☐ IV fluids charted

☐ Second IV access ☐ Fluid balance Chart

☐ No access required ☐ Failed IV access ☐ Arterial line ☐ Central venous line ☐ Time last voided

Fasted from ☐ Food ☐ Fluids ☐ Continent ☐ Incontinent

☐ Intercostal catheter ☐ Nasogastric tube ☐ Other ☐ Indwelling catheter

BACKGROUND

Past relevant medical history

Current episode medications *(refer to Medication Chart for time last given)*	Effect

Investigations *(results if available)* Results attached ☐ Yes ☐ No

Relevant Social issues

ALERTS

Mental Health Act
- ☐ Voluntary
- ☐ Involuntary
- ☐ Risk assessment

Drug Allergy
- ☐ *(state drug/reaction)*

AGREED PLAN

Dietary needs	Mobility
Receiving hospital	Unit
Receiving doctor	Contact number
Bed arranged with:	Confirmed bed ☐ Yes ☐ No
Transfer form faxed to receiving hospital	☐ Yes ☐ No

- ☐ Forensic
- ☐ Bariatric Client
- ☐ Microbiological
- ☐ Pressure area risk
- ☐ Other:

ATTACH ALERGY STICKER

WACHS MEDICAL RECORD TRIAL INTER HOSPITAL TRANSFER

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Inter Hospital Patient Transfer
ADULT/CHILD Handover (cont.)

AGREED PLAN

Medication orders ☐ Charted ☐ SJAA Medication Form *completed for road transfer*

Observation/frequency

Advice given *(and by whom)*

Transfer Information Patient Weight Patient Height Patient Luggage *1 Piece <8kgs)* ☐ Yes ☐ No

The treating Medical Officer *(or most senior clinician)* must authorise this section

Name of medical officer _____ Signature

Mode of transport ☐ Private ☐ St Johns Ambulance ☐ Emergency helicopter ☐ Commercial plane ☐ Health service car ☐ RFDS (fixed wing) ☐ Commercial bus/train ☐ Other

Escort ☐ None ☐ Carer ☐ Driver ☐ Registered midwife ☐ Doctor ☐ Registered nurse ☐ Enrolled nurse ☐ Mental health nurse ☐ Ambulance officer ☐ Paramedic ☐ Police Escort weight *(aeronautical transfer only)* Kg

Positioning ☐ Sitting ☐ Stretcher ☐ Physical restraint required ☐ Other

WACHS Clinical Urgency for transfer ☐ Resuscitation *(immediate)* ☐ Emergent *(request transfer within 4-6 hours)* ☐ Urgent *(transfer within24hrs)* ☐ Semi urgent *(within 24-36 hrs)* ☐ Non urgent *(greater than 36hrs)*

Transport Providers Tasking Priority ☐ SJAA ☐ RFDS ☐ Priority 1 ☐ Priority 2 ☐ Priority 3

READ BACK

Interventions *(Clarify points, who is responsible for organising what, interventions required and by whom)*	By Whom	By When

Psychiatric patient information

PSYCHIATRIC

Case worker name and contact no. Forms under the Mental Health Act ☐ Completed ☐ Nil

☐ Mental state examination ☐ Other agency involvement *(whom)*

☐ Rural link 1800 552 002 contacted for advice (after hours)

Airway compromised ☐ Yes ☐ No ☐ Airway management plan - see front of chart

Sedation	Time	Effect

Completed by *(print, sign, designation)* Date/Time Patient discharged time: