### Inter-Hospital Patient Transfer Form

**Government of Western Australia**  
**WA Country Health Service**

**Inter Hospital Patient Transfer**  
**ADULT/CHILD HANDOVER**

<table>
<thead>
<tr>
<th>Surname</th>
<th>URN</th>
<th>Given Names</th>
<th>DOB</th>
<th>Address</th>
<th>Postcode</th>
<th>Gender</th>
</tr>
</thead>
</table>

**Date**  
**Time**

- **Medicare No.**
- **Ambulance fund number**
- **DVA colour and number**

- **AB**  
- **TSI**  
- **ABTSI**

**Primary language spoken**  
**Interpreter required**

- **Yes**  
- **No**

- **Contact person/INOK**
- **Contact No.**
- **NFR status documented**

- **Yes**  
- **No**

**Aware of transfer**

- **Yes**  
- **No**

**Organ donor**

- **Known**  
- **Unknown**

**Referring hospital contact person:**

- **Name**
- **Contact number**

**Signature**  
**Usual GP/Contact No.**

**Reason for transfer**

**Principle diagnosis/problem**  
**Other diagnoses/problems**

### Situation

**Airway**

- **Compromised**
- **Ventilated**

**Breathing**

- **Shallow**
- **Deep**
- **Rapid**
- **Slow**

**Colour**

- **Unremarkable**
- **cyanotic**

**Circulation**

- **Unremarkable**
- **Mottled**
- **Cyanotic**

**Skin**

- **Unremarkable**
- **flushed**
- **cool/cold**

**Pulse**

- **Unremarkable**
- **Irregular**
- **Slow**

**Behavioural**

- **Harm to self**
- **Harm to others**
- **Requires physical restraint**
- **Strong**
- **Weak**
- **Usual conscious state (if known)**

**Airway management plan**

**Airway compromise relayed to transport provider**

- **Yes (Time)**
- **No**

**Outcome:**

- **Temp.**
- **Pulse**
- **Resp rate**
- **B.P.**
- **SpO2**
- **O2 rate/device**
- **Pain Score**

- **IV fluids charted**
- **Fluid balance Chart**
- **Time last voided**
- **Fasted from Food**
- **Fluids**

- **Intercostal catheter**
- **Nasogastric tube**
- **Other**
- **Indwelling catheter**

**Past relevant medical history**

**Current episode medications**

- **(refer Medication Chart for time last given)**

**Investigations**

- **(results if available)**
- **Results attached**

**Drug Allergy**

- **(state drug/reaction)**

**Relevant Social issues**

**Dietary needs**

**Mobility**

**Receiving hospital**

**Receiving doctor**

**Contact number**

**Bed arranged with:**

- **Confirmed bed**
- **Other**

**Transfer form faxed to receiving hospital**

- **Yes**
- **No**
## Inter-Hospital Patient Transfer Form

**WACHS Clinical Handover Initiative**

### Surname

**URN**

### Given Names

**DOB**

### Address

**Postcode**

**Gender**

### Inter Hospital Patient Transfer

#### Adult/Child Handover (cont.)

<table>
<thead>
<tr>
<th>Medication orders</th>
<th>Charted</th>
<th>SJAA Medication Form completed for road transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation/frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice given (and by whom)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Transfer Information

<table>
<thead>
<tr>
<th>Patient Weight</th>
<th>Patient Height</th>
<th>Patient Luggage (8kgs)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Name of medical officer</th>
<th>Signature</th>
</tr>
</thead>
</table>

### Mode of transport

- Private
- St John's 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
- Elivest (aeronautical transfer only)

### Positioning

- Sitting
- Stretcher
- Physical restraint required
- Other

### WACHS Clinical Urgency for transfer

- Resuscitation (immediate)
- Emergent (request transfer within 4-6 hrs)
- Urgent (within 24-36 hrs)
- Semi urgent (within 24-36 hrs)
- Non urgent (greater than 36hrs)

### Transport Providers Tasking Priority

- SJAA
- RFDS
- Priority 1
- Priority 2
- Priority 3

### Interventions

(Clarify points, who is responsible for organising what, interventions required and by whom)

<table>
<thead>
<tr>
<th>By Whom</th>
<th>By When</th>
</tr>
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</table>

### Psychiatric patient information

- Case worker name and contact no.
- Mental state examination
- Forms under the Mental Health Act Completed Nil
- Rural link 1800 552 002 contacted for advice (after hours)
- Airway compromised Yes No
- Airway management plan - see front of chart

<table>
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<tr>
<th>Sedation</th>
<th>Time</th>
<th>Effect</th>
</tr>
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</table>

### Completed by

- (print, sign, designation)
- Date/Time
- Patient discharged time: