Department of Veterans Affairs

INTER-FACILITY TRANSFER FORM

GUIDELINES FOR TRANSFERRING PATIENTS FROM EMERGENCY DEPARTMENT

1. Notify receiving facility by telephone; then document the time, name of person contacted at receiving facility and name of person at VAMC (VA Medical Center) who made the call.
2. Confirm that physician to be responsible for the patient's care at the receiving facility has been contacted. Document time and name of person who made the call (this should be a physician.)
3. Document the reason patient is being transferred (patient request, no beds, etc.)
4. Make photocopies of all Emergency Department records and send with the patient to receiving facility.
5. Sign transfer form after all above are completed; attach copy of records going with patient to receiving facility. Retain original with hospital records.

TO BE COMPLETED FOR EVERY TRANSFER REQUEST TO AND FROM A VA MEDICAL FACILITY

SECTION I - DEMOGRAPHIC AND ELIGIBILITY INFORMATION

1. VETERAN'S LAST NAME- FIRST NAME- MIDDLE INTIAL		4. ADDRESS
2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	
5. DATE AND TIME		
6. ELIGIBILITY FOR VA CARE		7. ELIGIBILITY FOR TRAVEL/SPECIAL MODE

8. PATIENT HAS ADVANCED DIRECTIVE ☐ YES ☐ NO *(If Yes send copy with patient)*

9A. NAME OF CONTACT	9B. TITLE OF CONTACT	9C. TELEPHONE NUMBER

NOTE: PHYSICIAN IS TO COMPLETE THE REMAINDER OF THIS FORM

SECTION II - REASON FOR TRANSFER

1. NATURE OF SERVICES NEEDED BY PATIENT REQUIRING TRANSFER *(Identify)*

☐ DIAGNOSIS ☐ RETURN TO PRIMARY HEALTH FACILITY ☐ SERVICE NOT AVAILABLE AT REFERRING FACILITY

☐ TREATMENT ☐ CONSULTATION/EVALUATION ☐ NO BED AT REFERRING FACILITY

☐ LONG TERM CARE ☐ OTHER *(Specify)* _____

2. DESCRIBE SERIVICES NEEDED

SECTION III - TYPE AND LEVEL OF SERVICES REQUIRED

1. DIAGNOSIS

2. DESCRIPTION OF TREATMENT PRIOR TO TRANSFER

3. DESCRIPTION OF FURTHER TREATMENT CONTEMPLATED

4. LEVEL OF CARE PRIOR TO TRANSFER *(ER, Outpatient, Ward, ICU etc.)*

1. VETERAN'S NAME	2. SOCIAL SECURITY NO.

SECTION IV - CONDITION OF PATIENT ON TRANSFER

1. IS PATIENT MEDICALLY STABLE FOR TRANSFER ☐ YES ☐ NO	DESCRIBE *(e.g. vital signs, significant history, physical findings, mental status, airway status, lab tests etc.)*
1. IS PATIENT BEHAVIORALLY STABLE FOR TRANSFER ☐ YES ☐ NO	DESCRIBE

SECTION V - MODE OF TRANSPORTATION

1. DESCRIBE SPECIAL MODE AND STAFF REQUIREMENTS

2. IV MEDICATIONS OR OTHER TREATMENTS ON ROUTE

SECTION VI - INFORMATION TO BE SENT WITH PATIENT

☐ COMPLETE MEDICAL RECORD ☐ DISCHARGE SUMMARY ☐ TRANSFER NOTE ☐ ER NOTE ☐ CLINIC NOTE

☐ OTHER *(Imaging studies, laboratory reports, EKGs, etc.)*

SECTION VII - PATIENT/FAMILY CONSENT RECEIVED ***(Must be completed for every transfer of an unstable patient.)***

☐ PATIENT CONSENTS TO TRANSFER	☐ REFERING PHYSICIAN CERTIFIES THAT BENEFITS OF TRANSFER OUTWEIGH RISKS

SIGNATURE (Sign in ink):

SECTION VIII - RESPONSIBLE INDIVIDUALS

1. NAME OF TRANSFERRING/RECEIVING PHYSICIAN AT THIS FACILITY	2A. TRANSFERRING/ACCEPTING FACILITY FACILITY
2B. NAME OF PHYSICIAN	2C. TELEPHONE NUMBER

SECTION IX - DECISION ***(To be completed for all transfer requests into a VA facility.)***

☐ 1. NOT ACCEPTED *(Specify reason)* ☐ 2. ACCEPTED *(Complete items 2A through 2H below)*

2A. NAME AND WARD OF VA ACCEPTING PHYSICIAN	2B. DATE AND TIME OF TRANSFER
2C. TRANSPORTATION AUTHORIZED. ☐ YES ☐ NO	2D. NON-VA MEDICAL SERVICES AUTHORIZED. ☐ YES ☐ NO

2E. NAME AND SIGNATURE *(Sign in ink)* OF PHYSICIAN COMPLETING THIS FORM	2F. TELEPHONE NUMBER	2G. DATE AND TIME

Department of Veterans Affairs

INTER-FACILITY INFECTION CONTROL TRANSFER FORM

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer. ***Please attach copies of latest culture reports with susceptibilities if available.***

SECTION I - SENDING HEALTHCARE FACILITY

1. PATIENT/RESIDENT LAST NAME	2. FIRST NAME	3. DATE OF BIRTH	4. MEDICAL RECORD NUMBER

5. NAME/ADDRESS OF SENDING FACILITY	6. SENDING UNIT	7. SENDING FACILITY PHONE

8. SENDING FACILITY CONTACTS	NAME	PHONE	EMAIL
CASE MANAGER/ADMIN/SW			
INFECTION PREVENTION			

SECTION II - INFECTION/HEALTH INFORMATION

9. IS THE PATIENT CURRENTLY IN ISOLATION? ☐ YES ☐ NO

10. TYPE OF ISOLATION *(Check all that apply)* ☐ CONTACT ☐ DROPLET ☐ AIRBORNE ☐ OTHER: _____

11. DOES PATIENT CURRENTLY HAVE AN INFECTION, COLONIZATION OR A HISTORY OF POSITIVE CULTURE OF A MULTIDRUG-RESISTANT ORGANISM (MDRO) OR OTHER ORGANISM OF EPIDEMIOLOGICAL SIGNIFICANCE?	COLONIZATION OR HISTORY *(Check if yes)*	ACTIVE INFECTION ON TREATMENT *(Check if yes)*
METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)	☐	☐
VANCOMYCIN-RESISTANT ENTEROCOCCUS (VRE)	☐	☐
CLOSTRIDIUM DIFFICILE	☐	☐
ACINETOBACTER, MULTIDRUG-RESISTANT*	☐	☐
E COLI, KLEBSIELLA, PROTEUS ETC. W/EXTENDED SPECTRUM B-LACTAMASE (ESBL)*	☐	☐
CARBAPENEMASE RESISTANT ENTEROBACTERIACEAE (CRE)*	☐	☐
OTHER:	☐	☐

12. DOES THE PATIENT/RESIDENT CURRENTLY HAVE ANY OF THE FOLLOWING?

☐ COUGH OR REQUIRES SUCTIONING
☐ DIARRHEA
☐ VOMITING
☐ INCONTINENT OF URINE OR STOOL
☐ OPEN WOUNDS OR WOUNDS REQUIRING DRESSING CHANGE
☐ DRAINAGE *(Source)* _____
☐ CENTRAL LINE/PICC *(Approx. date inserted* _____*)*
☐ HEMODIALYSIS CATHETER
☐ URINARY CATHETER *(Approx. date inserted* _____*)*
☐ SUPRAPUBIC CATHETER
☐ PERCUTANEOUS GASTROSTOMY TUBE
☐ TRACHEOSTOMY

13. IS THE PATIENT/RESIDENT CURRENTLY ON ANTIBIOTICS? ☐ YES ☐ NO

14. ANTIBIOTIC AND DOSE	TREATMENT FOR:	START DATE	ANTICIPATED STOP DATE

15. VACCINE	DATE ADMINISTERED *(If known)*	LOT AND BRAND *(If known)*	YEAR ADMINISTERD *(If exact date not known)*	DOES PATIENT SELF REPORT RECEIVING VACCINE?
INFLUENZA *(Seasonal)*				☐ YES ☐ NO
PNEUMOCOCCAL				☐ YES ☐ NO
OTHER:				☐ YES ☐ NO

16. PRINTED NAME OF PERSON COMPLETING FORM	17. SIGNATURE	18. DATE

19. IF INFORMATION COMMUNICATED PRIOR TO TRANSFER: NAME AND PHONE OF INDIVIDUAL AT RECEIVING FACILITY