مستشفى مارينا الاهلي
Patient Transfer / Referral Out

Patient ID Label

Date: Time :

Transfer Health Care Facility: ……..……
Unit: ……....
Transfer Health Care Facility Tel: .....
Ext. …….
Arrange by: ……

Receiving Health Care Facility: …….
Unit: ……
Receiving Physician: …….
Receiving Health Care Tel: ..... / Ext. ……
Arrange by: …….

Type of Service:
□ Emergency Transfer □ Non-Emergency Transfer □ Referral

Transportation mean: □ Ambulance □ Patient Own Vehicle □ Hospital Bus
Monitoring Required during Transport: _____
_____

Patient requires Transportation & Medical Supervision by : _____

Significant Findings:
Vital Signs upon Transfer: B p: _____ Temp: _____ R.R.: _____ H.R._____
Patient Diagnosis: _____

Reason for Transfer / Referral: _____
Patient Condition at Transfer Time: _____

Are there any other Records / Files being sent with the patient? □ Yes □ No (if Yes please list below)
_____ _____
_____ _____

List of Current Medications:
_____ _____
_____ _____

Recommendation:
_____
_____

Patient Status Upon Receiving:
_____
_____

Sending Physician Name: _____
RN Name: _____ Signature: _____
Receiving Doctor / Nurse Name: _____ Signature: _____
Date :_____ Time :_____

To be Filled by Physician (For Medical Referral Reasons)	
Date of Transfer :	Time
Diagnosis: _____	
Summary History and Reason for Admission_____	
Significant Lab / X–Ray / ECG & Physical Findings: _____	
Procedure and Medication Given: _____	
Consultations and Physician Following Up: _____	
Patient Condition on Transfer: _____	
Plan of care: _____	
Notes: _____	
Attending Physician Name: _____ Signature: _____	
Written by Dr.: _____ Signature: _____ Date: _____	