Patient ID Label

مستشفى مارينا الاهلي

PATIENT TRANSFER IN

هذا الجزء يعبأ من قبل الممرض المسؤول

Date of Transfer : **Time :**

Patient Name : ______ **Age** ______ **MR#** ______
☐**Emergency transfer** ☐**Non Emergency Transfer**
Receiving unit /dept: ______ **Room :** ______
Sending unit / dept. ______ **Room** ______
Reason of transfer : ______
Patient condition at transfer time : ______
Method of transfer : ☐**On bed** ☐**On Wheel chair** ☐**Stretcher** ☐**Other**
Patient requires transportation & medical supervision by ______

______

Does the patient have any personal property / items going with them ? ☐ **Yes** ☐**No**
If Yes, List Below :

______

______

Check list

No	List of items sent with patient	Yes	no	Remark
1	Patient medical record			
2	Old medical record			
3	Transfer order			
4	Medication			
5	X- Ray			
6	Lab – invest			
7	IV access			
8	Wound Drains			
9	Patient possessions			
10	Any Surgical procedure (If yes Specify site)			
11	Others			

Medications:

1	2
3	4
5	6
7	8
9	10
11	12
13	14

☒ **Sending Nurse :** ______ **Signature :** ______
☒ **Receiving Nurse :** ______ **signature :** ______

QI\MR33