UHN Toronto General Toronto Western Princess Margaret Toronto Rehab

Addressograph

Patient Transfer Summary

Date:_____/_____/_____ dd mm yyyy	**CODE STATUS:** ❑ **Full Code** ❑ **No CPR** **Special considerations:**
Diagnosis:	**Emergency Contact:** Name: _____ Relationship: _____ Phone #: _____
Reason for Transfer: ❑ Treatment ❑ Medical Imaging ❑ Emergency ❑ External Institution Other:_____	**Substitute Decision Maker:** Name: _____ Relationship: _____ Phone #: _____
Isolation: ❑ Yes ❑ No **Type:** ❑ **Contact** ❑ **Airborne** ❑ **Droplet** Reason for Isolation:	**Allergies:** ❑ **Yes** ❑ **No** **If yes, specify**
Consent(s) Included:	

SPECIAL CONSIDERATIONS:

Behavioural Safety Alert: ❑ Yes ❑ No If yes, specify:_____	Mental Status: ❑ Alert ❑ Confused Other: (describe)_____
Is a person required to accompany the Patient? ❑ Yes ❑ No If yes, (select most applicable box): ❑ RN ❑ RPN ❑ PSW ❑ Porter ❑ Family Member	
Preferred Language: ❑ English ❑ Other:_____ Translator Required: ❑ Yes ❑ No	Physical Impairments: ❑ Yes ❑ No Comments:
Ambulation: ❑ Independent ❑ With Assistance ❑ Total Assist Assisted devices required: ❑ Yes ❑ No Type: _____	

CLINICAL STATUS

Current Vital Signs (date/time):	BP:	Temp:	Pulse:	Resp:
Vascular Access : ❑ PIV ❑ CVAD ❑ Port-a-cath Accessed: ❑ Yes ❑ No Intravenous solution and rate:	Oxygen Saturation: Oxygen Required: ❑ Yes ❑ No Amount/Type: ❑ Nasal prongs____L/M ❑ Face Mask ___% ❑ Tracheostomy ❑ Other_____			
Medical Drains: (select all that apply) ❑ Foley ❑ Chest Tube ❑ J/G Tube ❑ Other:_____				
Medication Administration Record Sheets attached: ❑ **Yes** ❑ **No**				

Patient Returned to Transferring Unit/Area: : ❑ **Yes** ❑ **N/A** **Signature:** _____

For external transfer only

Transferring Unit/Area:	**Receiving Unit/Area:**
Clinician Name: (print first & last)	**Clinician Name:** (print first & last)
Signature:	**Signature:**

MASTER RECORD OF SIGNATURES (Used only for Princess Margaret Cancer Centre staff)

Nurses must:

1. Review the Patient Transfer Summary form prior to patient leaving the unit to go for treatment/ procedure.
2. Include date, time and signature in the chart below when the Patient Transfer Summary form has been reviewed.
3. If there are any changes, a new Patient Transfer Summary must be completed prior to the patient leaving the unit.

Date	Time	Full Name (print first and last)	Signature	Patient Returned to transferring unit/area (signature of receiver)	
				Yes	N/A