Interfacility Transfer Form

Patient Information

Weight __________ Height __________
Allergies _____________________________
Request Vital Signs: every __________ minutes
Current Vital Signs: B/P_____ HR______ RR_____ O2__

Patient Sticker

Medications: Transcribe current medication doses, infusion rates and titration instructions.

Medication Name	Infusion Rate/Dose	Administration/Titration Instructions

Ventilator Settings

Rate ________ Tidal Volume ________ I:E time ________ Volume/Pressure ________
AC/SIMV ________ CPAP/BiPAP ________ O2% ________ Sensitivity ________ PEEP ________
Alarms: High Pressure ________ Low Pressure ________
Comments/Additional Instructions ____
____

Other orders (OG/NG/Chest Tube, etc)____
____
____

RN information

The orders from the patient's electronic medical record related to this visit have been transcribed above.
Date __________ Time __________ RN signature ________________________

Provider (transporting agency) information

The above orders have been reviewed and approved.
Date ________ Time ________ Provider signature ____________________________

Sending Facility: ______________________________ Contact Phone#________________________
Receiving Facility: _____________________________ Contact Phone#________________________

CONTACT MEDICAL CONTROL WITH QUESTIONS

Not Part of Patient's Medical Record