DELAWARE INTERAGENCY PATIENT TRANSFER FORM - EMERGENT

Skilled Nursing Facility & Assisted Living Facility - ONLY - Starting 1-6-2020

Patient Name: _____ **DOB:** _____ **Last 4 digits of SSN #**_____ **Gender Pref.** ☐ **M** ☐ **F**

Transferring Provider Name: _____ **Transferring Provider Contact #** _____ **Provider Type:** Select

Primary Nurse Name : _____ **Primary Nurse Contact #** _____

Reason & Time for Transfer: _____

Patient receives supplemental services from another provider? **Yes** ☐ ☐ **No** **If Yes, Provide the following information:**

Provider Name: _____ **Contact Person Name:** _____

Contact Email: _____ **Contact Phone #:** _____

Referring Medical Practitioner & Contact # _____

Attend ing Medical Practitioner & Contact # _____

Responsible Party/POA Name & Contact # _____ Notified: ☐ Y ☐ N

Code Status (check status and attach related documents- Advanced Directive, DMOST):
☐ Full Resuscitation ☐ DMOST Order ☐ DNR ☐ DNI ☐ Comfort Measures only

Lines/Tubes/Drains (check if yes, placement site, date & location): Intubated ☐ Y ☐ N Foley ☐ Y ☐ N

IV/Central Line/PICC/Port ☐ Y ☐ N

Site: _____ Date Inserted: _____

Chest/Feeding Tube/Drain ☐ Y ☐ N

Site: _____ Date Inserted: _____

Allergies / reaction ☐ **(See attached)**

_____

_____

_____

_____

_____

Pain Level at Transfer (0-10) _____

_____

Blood Transfusion: ☐ Accepts ☐ Refuses

Special Precautions (type/date):
☐ MRSA ☐ VRE ☐ C-Diff ☐ CRE ☐ Rash

Comments: _____

Fall Risk/History: ☐ Y ☐ N ☐ High Risk

_____

Skin Breakdown: ☐ Y ☐ N

Pressure Ulcer _____

Vascular _____

Surgical _____

Aspiration: ☐ Y ☐ N

Risk _____

Baseline Mental Status (check all that apply):
☐ Alert/Oriented ☐ Agitated ☐ Somnolent ☐ Unresponsive ☐ Confused ☐ Non-Verbal

Baseline Mobility (check): ☐ Independent/Ambulatory ☐ Partial Assist ☐ Full Assist

Ambulatory Aids (check): ☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair

Form Completed by: _____ **Date & Time** _____

Transfer Facility SECURE HIPAA Compliant Fax Line #: _____

***** Disclaimer: Not all providers required to complete the Interagency Transfer Form - Emergent have or can provide all of the medical information on this form*****

TRANSFER PROTOCOL (as applicable):
(1) Obtain Order and Complete this Form
(2) Contact Receiving Facility
(3) Provide Report to Receiving Facility
*(4) Send this form & related available documents with transport team to facility***

*****Documents to send to Receiving Facility:***
- *Face Sheet, Past Medical History/Problem List*
- *Current MAR or Medication Reconciliation*
- *H & P, Recent Progress Notes, DC Summary*
- *Recent Lab & Imaging Results*

Transferring Provider Capabilities IN THE NEXT 24 HOURS (circle/check):

IV – Fluids Antibiotics Diuretics

☐ *Transfer back with IV access if placed*

☐ *Laboratory Testing Tomorrow*

☐ *Imaging Testing Tomorrow*

*Will Physician/Practitioner be able to see patient in the facility **TOMORROW?***

☐ *Yes* ☐ *Uncertain* ☐ *No*

Comments or suggestions regarding this form/process can be sent to: DHSS_DHCQ_OHFLCFax@delaware.gov

Updated - 11-22-2019

Delaware EMERGENCY DEPARTMENT Contact Information

Nemours Alfred I. Dupont Hospital for Children ED
P:302-651-4183
F:302-651-6716

Bayhealth Kent Campus ED
P: 302-744-7121
F: 302-735-3256

Bayhealth Sussex Campus ED
P: 302-430-5720
F: 302-430-5515

Bayhealth Smryna ED
P: 302-659-2190
F: 302-659-1937

Beebe Healthcare ED
P: 302-645-3554
F: 302-645-3407

Christiana Care- Christiana Hospital ED
P: 302-733-6806/1700
F: 302-733-1089

Christiana Care- Middletown Hospital ED
P: 302-203-1300
F: 302-203-1310

Christiana Care- Wilmington Hospital ED
P: 302-320-2623/4182
F: 302-320-4188

Nanticoke Health System ED
P: 302-396-3785/629-6611x2252
F: 302-628-6383

Saint Francis Hospital ED
P: 302-421-4333
F: 302-421-4858

Emergency Departments: Any changes to the phone or fax number must be immediately reported to the Division of Health Care Quality at 302-292-3930 or DHSS_DHCQ_OHFLCFax@delaware.gov

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