

PATIENT TRANSFER ORDERS

Date: _____ Time: _____

Name Receiving Hospital

Transferring Physician

Accepting Physician

Name of M.O.O.D./ Time notified

Above Confirmed By

Transfer Service or Agency

Contacted or Arranged By/Date Time

Method of Transfer

___ Helicopter ___ AMB. /ALS. ___ AMB. /BLS ___ Other: _____

Required Life Support Equipment and Medical Orders

Position on Gurney: Car Seat Fowlers Supine % Prone %
 Right or left Tilt Trendelenburg Reverse Trendelenburg

Diet: NPO clear liquid no limitations
Vital signs: q 5min q 10min q 15min q 30min q 1hr
Oxygen: None Nasal-canula @ ___ l/min Non-rebreather Mask @ ___ l/min
Saline-Lock: YES NO

IV Fluids: _____ @ _____ cc/hr IV Fluids: _____ @ _____ cc/hr

Medications: 1) IV IM SQ PO
Medications: 2) IV IM SQ PO

Foley to gravity NG-Tube to gravity Other: _____

Time of Arrival of Transport: _____ Transfer Time: _____

During transfer radio contact is to be maintained

On-line medical direction regarding the patient's care is to be exercised by:

___ Transferring Hosp. ___ Receiving Hosp. ___ Other _____

Copies of all medical records, including test, orders, consents, certifications and X-rays are to accompany the patient to the receiving facility.

Patient's Identification

Physician's Signature Date Time