**INFORMATION IN ITALICS IS FOR GUIDANCE ONLY.**

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| PATIENT NAME:  PATIENT CHI:  PATIENT ADDRESS:  AFFIX LABEL HERE | | ANTICIPATED OUTCOME OF TRANSFER:  *(E.G. REHABILITATION, ORGANISATION OF SOCIAL CARE)* | |
| **PRE-TRANSFER COMMUNICATION:** | | | |
| NAME OF CALLER |  | | |
| WARD/HOSPITAL/ TELEPHONE OF CALLER |  | | DATE: |
| **S:** SITUATION:  *Diagnosis/date of surgery* |  | | |
| **B:** BACKGROUND:  *Please consider: GP, Care manager, PMH, Social circumstances, Next of Kin plus contact information, etcetera* |  | | |
| **A:** ASSESSMENT:  *Please consider: Infection control, Mobility, Falls risk, aids, high risk meds*  ANY INFECTION RISK SHOULD BE DISCUSSED WITH INFECTION CONTROL |  | | |
| **R:** RECOMMENDATION:*planned transfer date* |  | | |
| SIGNATURE, NAME AND DESIGNATION OF PERSON ACCEPTING TRANSFER |  | | |
| **PRE-TRANSFER PLANNING AND ACTION:** | | | |
| IDENTIFY RECEIVING WARD |  | | |
| ASK TRANSFER WARD TO INFORM RECEIVING WARD OF TIME OF DEPARTURE OF PATIENT |  | | |

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| **AFTER TRANSFER CHECKLIST:** | |
| DATE AND TIME OF ADMISSION: |  |
| DOCUMENTATION SENT WITH PATIENT (MEDICAL AND NURSING LETTERS) |  |
| RESPONSIBLE ADMITTINGCLINICIAN INFORMED OF PATIENT ARRIVAL. |  |
| ESCALATE TO CLINICAL LEAD IF PATIENT HAS NOT BEEN ASSESSED BY ADMITTING STAFF WITHIN 24 HOURS | |

**FILE IN PATIENT’S NURSING NOTES**

**pATIENTS BEING TRANSFERRED FROM ANOTHER HOSPITAL SHOULD BE ADMITTED TO A SINGLE ROOM WITH ENSUITE SHOWER**