Sioux Lookout Zone Nursing Office, Health Canada - First Nations Inuit Health

PATIENT TRANSFER NOTE

DATE:_____

Nursing Station:_____

Physician Consulted:_____ **Time:**_____

Receiving Physician:_____

Receiving Facility:_____

Addressograph

Elective:_____ **Emergency:**_____ **ALLERGIES:**_____

MEDCOM:
Emergency 1-800-387-4672 Non Emerg 1-800-387-4675 www.ornge.ca
Pt Transfer Authorization Number_____ (blank form on Forms CD or website)

PROVISIONAL DIAGNOSIS:_____

Special Needs: Interpreter:_____ **Escort:**_____ **Other**_____

Immunization: Up-to-date_____ **Requires (Specify)**_____ **Date Last Tetanus**_____

TB Skin Test:_____ **Result:**_____ **CXR:**_____

Emergency/ Stat Drugs administered at Nursing Station

Drug, dose, frequency, route	Date last adm.	Time last adm.	Comments	CHN sign.

Date/Time	Treatment (IV, O2)

Past Medical History

Transferred with patient:

Photocopy of Nurses Notes □ **Chronic Med Profile** □ **X-ray** □ **Lab work** □ **ECG** □
Special Equipment □_____

_____ _____
Signature of Nurse **Date & Time**

Please send consult/discharge summary to the Referring Facility/Nursing Station

March 09