Inter-Hospital Clinical Handover Form

Patient Details

Name

Date of Birth

MRN/ID

Gender

Contact Number

Referring Hospital / Unit

Hospital Name

Unit / Ward

Referring Doctor

Contact Number

Date

Time

Receiving Hospital / Unit

Hospital Name

Unit / Ward

Receiving Doctor

Contact Number

Clinical Summary

Presenting Problem & Clinical Background

Current Management

Allergies

Medications / Treatments

List medications, infusions, therapies, etc.

Investigations & Results

Key recent results / pending investigations

Plan & Recommendations

Management plan, outstanding tasks, suggested follow-up, etc.

Handover by (Name & Position)

Signature

Date