Patient Inter-Hospital Transfer Summary

Patient Details

Name:

Date of Birth:

Medical Record #:

Gender:

Transferring Facility

Facility Name:

Physician:

Contact Number:

Receiving Facility

Facility Name:

Physician:

Contact Number:

Diagnosis & Reason for Transfer

Relevant History & Examination

Investigations & Results

Treatment Given

Medications on Transfer

Allergies

Other Notes/Special Instructions

Transferring Physician Signature & Date

Receiving Physician Signature & Date