

Pediatric Inter-Hospital Transfer Documentation Form

Patient Name: Date of Birth: MRN:

Transferring Facility: Receiving Facility: Date &

Time of Transfer:

Reason for Transfer:

Diagnosis:

Medical History / Summary

Examination Findings

Vital Signs at Transfer

Time	HR	RR	BP	Temp	SpO ₂	Other

Medications/Fluids Given

Name	Dose	Route	Time	Remarks

Procedures Performed

Ongoing Management / Special Instructions

Escort Team Details

Names & Designation: Contact:

Signatures

Referring Doctor: Date & Time:

Receiving Doctor: Date & Time: