McLAREN - FLINT
Surgery & Endoscopy Center
510 South Ballenger Highway
Flint, MI 48532
810-768-2044

PATIENT TRANSFER FORM

Date _____ Transferring Physician_____

Patient name _____ Age _____ Male ❑ Female ❑

Receiving hospital _____

Report given to _____All medications communicated in report ❑

Time Hospital contacted _____

Diagnosis/Reason for transfer_____

_____

Reason for admission to Surgery Center _____

Vital signs on arrival: Time _____ B/P _____ P _____ R _____ T _____

Vital signs on discharge: Time _____ B/P _____ P _____ R _____ T _____

I.V. Solution _____ I.V. Site _____ Gauge _____

Documentation	Sent	N/A	Paragon	Documentation	Sent	N/A	Paragon
Transfer Form	❑	❑	❑	Health History	❑	❑	❑
Lab Work	❑	❑	❑	O.R. Record	❑	❑	❑
EKG	❑	❑	❑	Anesthesia Record	❑	❑	❑
Other:	❑	❑	❑	PACU Record	❑	❑	❑

Method of transfer: Ambulance ❑ Ambulance Service _____

Physician Reassessment _____

It is my medical judgment that this transfer will not create a medical hazard to this patient.

Physician Signature _____ Date _____ Time _____

I acknowledge and understand that I have been advised by Dr. _____ that I am being transferred to the above facility for the reason specified above.

Patient or Patient Representative Signature _____ Date _____

Witness Signature _____ Date _____

Form completed by _____ Date _____

White Copy: Chart
Yellow Copy: Clinical Practice
Pink: Transfer Chart

PATIENT TRANSFER FORM

17835 (5/12)

060B

PT.

MR.#/RM.

DR.