

To be filled out by Provider:

Provider shall be one of the following: MD, DO, APRN, PA

Is the patient considered LOW RISK*?

(All of the following must apply to the patient)

- Young (equal to/less than 45 y/o)
- Presenting with isolated psychiatric complaint
- Past history of psychiatric illness
- No report of, or concern for, substance intoxication, withdrawal, or exposure to toxins/drugs
- History/physical exam does not suggest medical illness

☐ YES ☐ NO

****If patient is considered LOW RISK, no further diagnostic testing is required other than at the discretion of the Clinician.***

What is the working psychiatric diagnosis?

Females between 12-60 yo, pregnancy test results:

☐ Positive ☐ Negative ☐ N/A: _____

Any abnormal vital signs at time of transfer?

- Temperature =>101F
- HR <50 or >120
- SBP <90 or >200
- RR >24
- BGL <60 or >250
- Outside normal range for pediatric age

☐ YES ☐ NO

Any active medical problems that will need to be addressed at the receiving facility (i.e.: suture/ staples needing to be removed, antibiotics for cellulitis or UTI, etc.)

☐ YES ☐ NO

If yes, please provide instructions:

Is the patient medically stable for transfer to a psychiatric facility?

☐ YES ☐ NO

Completed by: _____

Title: _____

While the sending physician ensures patient stability and provides necessary orders for transfer, the transporting agency physician has the final decision on appropriateness of patient for transfer, prioritizing both patient and medic safety.

To be filled out by the Transfer Coordinator:

Is the patient under Emergency Detention/ Mental Health Warrant/ Magistrate ED?

☐ YES ☐ NO

If yes, date/time: _____

Is the patient under Order of Protective Custody (OPC)?

☐ YES ☐ NO

If yes, date/time: _____

For pediatric patients, provide the name and contact info for parent/guardian/CPS Case Worker:

Is the patient able to perform basic ADLs (transfer without assist, toilet, self-care, etc.)?

☐ YES ☐ NO

Does the patient require an assistive device for mobility?

☐ YES ☐ NO

If yes, what device? _____

Does the patient have inserted/implanted devices with external tubes/wires?

☐ YES ☐ NO

If yes, what device? _____

At the time of transfer, make sure the following items are included in the transfer packet:

- ☐ Nursing notes
 - ☐ Clinician notes
 - ☐ Lab results (if performed)
 - ☐ Med Administration Record (if meds given)
 - ☐ Copy of all legal documents
- (If person is on ED/MHW/OPC, the document **must** be forwarded to receiving facility)

Completed by: _____

Title: _____