Manitoba Information Transfer Referral Form
Guidelines for Completion

Effective communication is a key component of Quality Patient Care. Information Transfer is also a Required Organizational Practice (ROP) as directed by Accreditation Canada. This form should be completed each time a patient transfers from one setting of care to another setting of care, regardless of reason for transfer and includes use for all ambulatory/out-patient visits and in-patient transfers.

Data Required	Completion Instructions	Source
Sending Facility/Program Required Information		
Transfer From	Enter referring facility, agency and/or department with location and phone number	Recorder
Transfer To	Enter receiving facility, agency and/or department with location (e.g. unit name) if known and phone number	Recorder
Accepting Physician/ Practitioner	Enter name of Physician/Practitioner who has accepted care for the patient. Enter name of other physicians/specialists who have been involved in the care/transfer of the patient	Chart
Sending Physician/ Practitioner	Enter name of Physician/Practitioner who is currently providing care for the patient	Chart
Nurse to Nurse Report Given	Verbal report should be given. Check “Yes” or “No”	Recorder
Date and Time of Transfer	Enter DD/MMM/YYYY of transfer/referral and time	Recorder
Organ Donation	Check “Yes”, “No”, or “Unknown”	Chart or Patient/Family
Patient Identification		
Addressograph Patient ID applied	Addressograph form on top right hand corner of form if available at referring facility	Patient ID card
Surname	Enter patient’s surname, if **NO** addressograph available.	Chart
Given Name	Enter patient’s given name if **NO** addressograph available. Enter patient’s given name on top of page 2 if form is not double sided.	Chart
Date of Birth	Enter patient’s birth date if **No** addressograph available. DD/MMM/YYYY	Chart
Sex	Enter patient’s sex in **No** addressograph available. Male or Female	Chart/observation
Health Record Number	Enter patient’s health record number if **No** addressograph available. Facility health record number (patient’s chart number)	Chart
Provincial Health Care Number	Enter patient’s MB Health number if **NO** addressograph available	Chart or MB Health card
PHIN	Enter patient’s 9 digit Personal Health Identification Number if **NO** addressograph. Enter patient’s 9 digit Personal Health Identification Number on top of page 2 if form is not double sided.	Chart or MB Health card
Patient ID Applied	Check to ensure patient has ID band affixed and that it is legible. Use 2 patient identifiers to ensure correct ID band is applied to the patient.	

CARE Alerts		
Allergies or Drug Reactions	List any known allergies or drug reactions for patient. **If no known allergies, check box.**	Chart or Kardex
Infection Control Precautions		
Do you have an outbreak in your facility or on your ward?	Check the "Yes or No" box. If "Yes" identify type of outbreak on the "Specify" line	Chart or Infection Control Notices for facility/ward
Infection Prevention & Control Precautions	Check the box(es) for type of precautions required. If "Other" type of precaution identify on the "Other" line	Chart/Kardex
Antimicrobial Resistant Organism Status	MRSA Positive check "Yes or No" MRSA Suspect check "Yes or No" MRSA Previous Positive check "Yes or No"	Chart/Kardex
CPE Pos (Carbapenemase Producing Enterobacteriaceae)	CPE Positive check "Yes or No" CPE Suspect check "Yes or No" If "Other" type of precaution identify on the "Specify" line	Chart/Kardex
Health Directives/Advanced Care Plans and Safety		
Health Care Directive	Check the box as "Yes or No".	Chart/Health Care Directive form
Advanced Care Plan Status:	Check box as applicable	Chart/Advanced Care Plan Status form
Violence Prevention Program Alert	Check the box "Active Alert" or "No Alert". If Active Alert, affix the Violence Risk sticker or stamp in the box to the right (∞purple/violet infinity symbol)	Chart/Violence Risk Assessment form
At Risk for Falls	Check the box as "Yes or No"	Chart/Falls Assessment form
Behaviour	Check box if applicable for "Agitation", "Verbal Aggression" or "Physical Aggression" If any observed behavioural concerns document in the "Describe Observed Behaviour" lines	Chart
Security Issues/Visitor Restriction	Check box as "Yes or No". If Yes, document on the "Comments" line	Chart
Patient Held Under Mental Health Act - Form Number/Patient Information	Check box as "Yes or No". Provide the type of Mental Health Form. Check the box "Yes or No" if the patient is aware	Chart
Patient Demographics and Contact Information		
Patient's Address and Phone Number	Primary residence and home and/or cell number	Chart
Band & Treaty #	Enter patient's Band name and Treaty number/or 10 digit ID number, if known	Chart or Treaty Card
Private Insurance Provider and Policy Number	Enter patient's private insurance carrier and policy number e.g. Blue Cross, Group Life, etc.	Patient's insurance card or chart
Next of Kin	Enter next of kin or guardian's name, relationship and contact numbers	Chart or Kardex

Notified of Transfer	Check box as “Yes or No” for Next of Kin Public Trustee, Power of Attorney, or Health Care Proxy. If unable to contact any, document attempts.	Chart/Kardex
Public Trustee/Power of Attorney, Health Care Proxy	Check “Yes or No” if patient is under Public Trustee/Power of Attorney or Health Care Proxy. A Proxy is considered to be a Guardian or substitute decision maker. Enter name and phone number where indicated.	Chart
Languages Spoken/Understood	Enter patients first language followed by any other languages that may be spoken/understood	Chart
Interpreter Required	Check “Yes or No” in box	Chart
Primary Diagnosis and Co-Morbidities		
Primary Diagnosis and Co-Morbidities	Enter diagnosis and any co-morbidities, (i.e. Diabetic with Cardiovascular disease and Hypertension)	Chart
Reason for Transfer/Referral	Why is the patient being transferred (i.e. diabetic leg ulcer, not responding to treatments, consult with surgery for possible amputation)	Chart
Supporting Documentation		
Photocopies Enclosed	Check any photocopies that will be forwarded with patient. DO NOT SEND ORIGINALS. Can include assessments, discharge summaries, consults, results, care plans, medication administration records, etc. Write in any other photocopies enclosed that are not identified	Chart
Page 2: Write Patient’s Name and PHIN Number at Top of Page in Form is NOT Double Sided		
Special Considerations		
Oxygen	If applicable, check the box and “Specify” flow rate and administration device	Chart
IV/CVAD’s	If applicable, check the box and specify solution, flow rate, device and any other pertinent information related to IV/CVAD	Chart
Dressings/Sutures/Drains	If applicable, check the box and specify location, status, any concerns	Chart
Wounds	If applicable, check the box and specify location, status, including staging and any concerns If wound exists and is Stage III or greater, complete section on “Reported as CI” and indicate “Yes or No”	Chart
Tube Feeds/Flushes	If applicable, check the box and specify type of feeding solution, continuous or intermittent, time of last feeding, etc.	Chart
Other	If applicable, check the box and specify	Chart
Level of Function (At Time of Transfer)		
Cognition	Check box for “Intact or Impaired”	Chart
Follows Directions	Check box as “Yes or No”	Chart/Kardex
MMSE SCORE	Mini Mental Status Exam – enter score and date last completed (DD/MMM/YYYY)	Chart

MOCA SCORE	Montreal Cognitive Assessment – enter score and date last completed (DD/MMM/YYYY)	Chart
Safety Restraints Required	Specify type of safety restraint(s) required and reason	Chart
Ambulation	Check box as “Independent” or complete specifics for “Weight Bearing Status”	Chart
Mobility Equipment	Check box as applicable or if “other” specify type of equipment required	Chart
Transfer Status	Check type of assistance required to transfer as applicable	Chart
Dress	Check status as applicable	Chart
Hygiene	Check status as applicable	Chart
Feeding	Check status as applicable. Note Date/Time of last oral intake (DD/MMM/YYYY)	Chart
Dysphagia	Check box as “Yes or No”	Chart
Diet/Nutrition Supplement	Specify diet and/or Nutrition Supplement Note: Diet as Tolerated is not a valid diet status.	Chart
Patient Weight	Document in Kilograms	Chart
Bladder	Check status as applicable Note Date/Time of Catheter Insertion and Removal (DD/MMM/YYYY)	Chart
Time of Last Voiding	Note time	Chart
Bowel	Check status as applicable Note Date of last B.M. (DD/MMM/YYYY)	Chart
Vision	Check vision aides as applicable Note if they are accompanying the patient	Chart
Hearing	Check hearing aids as applicable Note if they are accompanying the patient	Chart
Dentures	Check dentures as applicable Note if they are accompanying the patient	Chart
Prosthetics	Specify type of prosthetic Note if prosthetic is accompanying the patient	Chart
Valuables	Check valuables as applicable Note if valuables including clothing are accompanying the patient	Chart
Other	Specify any other valuables, aids or equipment that is accompanying the patient (i.e. personal wheelchair)	Chart
Additional Comments/Information		
Additional Comments	This area can be used to capture any information that has not been collected in other areas or comment on any YES indications. If plan is detailed, <u>indicate</u> and attach as separate sheet.	Chart
Follow Up Appointments	Indicate any follow up appoints the patient may have indicating where and when	Chart

Print the Name/Title of the Recorder and signature		
Return Transfer and Discharge Information – (For Short Stays of Less than 24 Hours Only)		
Return Transfer and Discharge Information for Short Stays of less than 24 Hours	If a patient returns to the original referring site **within 24 hours**, then this section is to be completed by the discharging facility that the patient was transferred to for short - term care. Examples: Outpatient/Emergency visit from Personal Care Home or referral for specialty examination (ex. Diagnostics). **If length of stay is greater than 24 hours, initiate a new transfer/referral form**	Chart
Discharged From	Indicate the name of the facility and the name of the department/patient care area that the patient is being discharge from	Chart
Contact Phone Number	Indicate the phone number of the department/patient care area that the patient is being discharged from	Hospital telephone directory
Discharge Summary and Recommendations	**A discharge assessment summary is vital.** Please photocopy written entries in chart Complete all sections and provide photocopies of any information that is pertinent to communicate. Attach separate sheet for any information / instructions that cannot be captured in space provided.	Chart from Discharging facility or department (e.g. ER, Diagnostics. ClinDoc)
Follow Up Appointments	List any follow up appointments that may be required	Chart
Discharge Instructions	Provide a copy of written discharge instructions	Chart
Medication Reconciliation	Include • Admission Medication Reconciliation • Transfer Medication Reconciliation • Current Medication Administration Record	Chart
Accompanying Medications	List any medication sent with the patient. Note: Many rural facilities have limited after hours pharmacy services and may not have access to specialize drugs	Chart
Consultations	Include any consultation reports during the stay	Chart
Test Results	Include any Lab or Imaging reports during the stay	Chart
Patient Return to Facility/Department Communicated with	Report to sending facility. Indicate the name of the person contacted about the return transfer, their title, the date and the time (DD/MMM/YYYY)	Recorder
Discharge Facility Contact Information	Complete date, name, and title required in space provided	Recorder
Photocopies Enclosed	Check any photocopies that will be forwarded with patient. DO NOT SEND ORIGINALS. Can include assessments, discharge summaries, consults, results, care plans, medication administration records, etc. Write in any other photocopies enclosed that are not identified	Chart
Please send original Inter-facility Transfer form with the Patient and keep a photocopy of this form on the patient's Health Record.		