BC Pediatric Society - Medical Transfer Summary

Patient Surname(s): _____

Given Name(s): _____

PHN: _____ Date of birth (dd/mm/yyyy): _____

Youth Phone/Email: _____ Primary Contact: ☐ Yes ☐ No

Parent Guardian Phone/Email (optional): _____ Primary Contact: ☐ Yes ☐ No

Emergency Contact: _____

Projected Date of Transfer: _____ ☐ Urgent ☐ Not Urgent

Please send copies to:

- ☐ Family Physician (MRP)
- ☐ Adult Specialist(s)
- ☐ Patient
- ☐ Parent/Guardian
- ☐ BCCH Specialist

ADULT HEALTH CARE TEAM

Identified	Still to Identify	Not Applicable	Adult Healthcare Team Members		Phone	Fax
			Type	**Name**		
☐	☐	☐	Family Physician			
☐	☐	☐	Adult Specialist Purpose:			
☐	☐	☐	Adult Specialist Purpose:			
☐	☐	☐	Choose Here for Additional Team Members:			
☐	☐	☐	Choose Here for Additional Team Members:			
☐	☐	☐	Choose Here for Additional Team Members:			
☐	☐	☐	Choose Here for Additional Team Members:			

SUGGESTED OUTLINE FOR YOUR TRANSFER LETTER

☐ Please see attached transfer letter

SUGGESTED TOPIC	SUGGESTED CONTENT
Recommendations for Future Care	• Condition-specific and potential complications/late effects • Recommended investigations • Specialty-specific considerations • Ongoing, regular bloodwork
Condition Specific Information (For each condition)	• Date of diagnosis, initial and most recent tests • Co-morbidities • Advance directives • Clinical warnings, other unresolved issues in ongoing care
Mental Health and Substance Use Concerns	• Specific concerns re mental health and/or substance use
Psychosocial Considerations	• Psychosocial information e.g. behaviour/safety concerns, family dynamics, compliance with treatment
Past Medical History	• Problem List (date, event or diagnosis, outcome and plan)
Medications	• Name, dose, rationale, plan • Relevant previous medications - reasons for changing/discontinuing, contraindications and potential drug interactions • Form of contraception • Pharmacare Special Authority in place (if applicable) and for which medication(s)
Diagnostic, Laboratory and Other Relevant Results	• Lab reports, specialist consults and allied health provider reports
Allergies	
Immunizations	• Condition-specific immunizations protocols and alerts • Rationale for non-completion of recommended schedule • What future immunizations are required
Transfer of Care	• Timing when specialist(s) will take over care – requesting a confirmation letter for the acceptance of the patient

REFERRING PHYSICIAN

Referring Physician: _____

Tel: _____ Fax: _____

office stamp

This form provides a guideline or framework for medical information that has been identified as useful in transition process but may need to be adapted for individual patient transfers.

This form is adapted from the forms developed by OnTrac: www.ontracbc.ca

BC Pediatric Society - Medical Transfer Summary

Patient/Family Information Section

Patient Surname(s): _____

Given Name(s): _____

PHN: _____ Date of birth (dd/mm/yyyy): _____

Youth Phone/Email: _____ Primary Contact: ☐ Yes ☐ No

Parent Guardian Phone/Email (optional): _____ Primary Contact: ☐ Yes ☐ No

Emergency Contact: _____

PLEASE REVIEW AND COMPLETE THIS PAGE THEN RETURN TO YOUR COMMUNITY PEDIATRICIAN FOR REVIEW.

In the electronic version of this form, you will see that many of these items are linked - please click on the link if you need more information.

SPECIAL CONSIDERATIONS

Communication:

What is the language the patient speaks? _____

And the family? _____

Need Interpreter: ☐ Yes ☐ No Language: _____

Communication Strategies and Barriers (please describe below):

Disability:

Mobility: _____

Cognitive Disability:

☐ Mild ☐ Moderate ☐ Severe ☐ None

Adaptive Disability:

☐ Mild ☐ Moderate ☐ Severe ☐ None

Living Arrangements:

☐ With family ☐ On own ☐ Foster care ☐ Other

Current/Future Plans:

Current School: _____

Individual Education Plan (IEP): ☐ Yes ☐ No

Post-Secondary Plans: ☐ School ☐ Work ☐ Wants a job

Other: _____

Benefit Status:

Financial/Medication Assistance:

☐ Medical Services Plan (MSP)

☐ Fair Pharmacare ☐ Pharmacare Special Authority in place

☐ Plan W (formerly Non-Insured Health Benefits for First Nations and Inuit - NIHB)

☐ Extended Health

☐ Interim Federal Health Program

☐ Disability Tax Credit

☐ Private

Does this individual identify as an Aboriginal person, that is, First Nations, Métis or Inuit? ☐ Yes ☐ No Benefits: ☐ Yes ☐ No

Eligibility: ☐ Community Living BC ☐ People With Disabilities ☐ Choices in Support of Independent Living ☐ Plan G

Financial Ability to Pay for Meds/Equipment: ☐ Yes ☐ No

Other Considerations: Are the following in place?

Driver's License: ☐ Yes ☐ No

If no: Click here for Fitness to Drive Guidelines

Click here for information on the GF Strong Driver Rehab Services

Medical Orders for Scope of Treatment (MOST): ☐ Yes ☐ No

"No CPR" Form: ☐ Yes *(if yes, please attach a copy)* ☐ No

Palliative Care: ☐ Yes ☐ No

Advanced Directive: ☐ Yes ☐ No

Representation Agreement: ☐ Yes ☐ No

Power of Attorney: ☐ Yes ☐ No

ABRIDGED TRANSITION CLINICAL PATHWAY (complete pathways for complex and simple are *available here*)

	Patient		Parent/Guardian *(if applicable)*	
	Yes	No	Yes	No
Describes and names health condition(s)	☐	☐	☐	☐
Knows allergies to medications, food and/or other	☐	☐	☐	☐
Names medications, how taken, reasons for them and their side effects, can fill a prescription	☐	☐	☐	☐
Knows when to notify physician of health changes	☐	☐	☐	☐
Describes emergency plan – who to call for what, carries emergency information, and/or medic-alert	☐	☐	☐	☐
Can identify if feeling sad, depressed, anxious, hopeless or has difficulty sleeping, and knows what to do	☐	☐	☐	☐
Knows how to prevent pregnancy and sexually transmitted infections (STIs)	☐	☐	☐	☐
Understands eligibility and completes applications for adult home care and services (Community LIving BC, People With Disabilities, Choices in Support of Independent Living)	☐	☐	☐	☐
Plans formulated for guardianship and future financial planning	☐	☐	☐	☐

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