FACILITY TRANSFER SHORT FORM MEDICAL RECORD

INSTRUCTIONS: This form is to be used to collect patient information during a surge when electronic systems for documenting the provision of care are unavailable or nonfunctional. This *Facility Transfer Short Form Medical Record* can be utilized to capture pertinent assessment, diagnosis, and treatment information. This document should be completed for victims seeking medical attention and can be sent with transferred patients to the receiving facility. (Note: A disaster incident number (DIN) is a unique identifier established at the county level for persons being treated at facilities during healthcare surge.)

Demographic

Patient Name: _____ DOB/Age: _____
Parent/Guardian: _____ Primary Physician: _____
DIN: _____ MRN: _____
Allergies: _____ ☐ NKA

History

Chief Complaint: _____
Significant Medical History: _____
Last Menstrual Period: _____ Pregnancy Status: _____

Glasgow Coma Scale	
Eye	
Motor	
Verbal	
Total	

Field Triage Category: _____ Site Triage Category: _____
Pupil Size L: _____ Reactive: ☐ Yes ☐ No
Pupil Size R: _____ Reactive: ☐ Yes ☐ No
Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)
Circle pain[1] (Child/Other):

No hurt | Hurts little bit | Hurts little more | Hurts even more | Hurts whole lot | Hurts worst

Time recorded			
Temp			
Pulse			
Respiration			
Blood Pressure			
Notes			

Intake		Output	
Total		Total	

Special Dietary Needs: _____

Medications

Name	Route		Dose	Time Frequency

Physician initials: _____ Nurse initials: _____ Other initials: _____

Physical Exam

Cardiovascular: _____ Pulmonary: _____
Neurological: _____
Other Significant Findings: _____
Physician initials:

Re-Assessment

Date: _____ Time: _____
System Review: Temp: _____ Pulse: _____ Resp.: _____ Blood Pressure: _____
Lab Results: _____ X-ray Results: _____
Physician initials: _____ Nurse initials: _____ Other initials: _____

Procedure/Disposition

Pre-Procedure DX: _____ Post-Procedure DX: _____
Procedure: _____ Findings: _____
Condition of Patient Post Procedure: ☐ Critical ☐ Guarded ☐ Stable
Discharge Instructions (yes/no): Written: _____ Verbal: _____
Diet: ☐ Regular ☐ Soft ☐ Liquid ☐ Other: _____
Activities: ☐ No Restrictions ☐ Restrictions as Follows: _____
Discharge Medications: _____
Follow-up Visit: When: _____ N/A: _____
Condition at Discharge: ☐ Critical ☐ Guarded ☐ Stable ☐ Fair ☐ Deceased
Temp: _____ Pulse: _____ Resp.: _____ Blood Pressure: _____
Discharge: ☐ Home ☐ Shelter ☐ ACS ☐ SNF ☐ Deceased Date: _____
☐ Transfer: _____ ☐ Other: _____ Time: _____
Admitted: ☐ Time Admitted: _____
Physician Order: _____
Notes: _____
Physician initials: _____ Nurse initials: _____ Other initials: _____

[1] Wong, DL. Hockenberry-Eaton M. Wilson D Winkelstein ML. Schwartz P. Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis. 2001. p. 1301.