

PATIENT TRANSFER CHECKLIST



Sun City West Ambulance
Ambulance Dispatch 623-546-1200
Fax 623-544-5444 or transport@scwfire.org
Office 623-584-3500 www.scwfire.org

PATIENT NAME OR PATIENT LABEL

TRANSFER FROM: (FACILITY, ROOM, DEPT.)

TRANSFER TO: (FACILITY, ROOM, DEPT.)

TRANSFER INFORMATION

(PATIENT CARE NEEDS)

- OXYGEN @ _____ LPM
- CARDIAC MONITOR
- IV
- IV MEDICATIONS
- IV PUMP
- VENTILATOR
- PULSE OX
- OTHER _____
- OTHER _____

TRANSFER CHECKLIST

- DISCHARGE SUMMARY
- PATIENT FACE SHEET
- P.C.S.
- INSURANCE FORMS
- D.N.R.
- X-RAYS
- LABS
- PATIENT BELONGINGS
- FAMILY NOTIFICATION

SPECIAL INSTRUCTIONS:

HIPAA NOTICE

This sealed envelope contains protected health information generally identified in 42 U.S.C. § 132 (d) through (d) (8), and specifically defined in 45 C.F.R. Part 164.501, pursuant to the Health Information Portability and Accountability Act of 1996. This envelope is to be opened only by individuals involved in the health care of the individual whose records are in this envelope. If you are not invoked in the health care or direct treatment relationship of the individual whose records are in this envelope, do not open this envelope.