



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		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Physician			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult Specialist Purpose:			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult Specialist Purpose:			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

SUGGESTED OUTLINE FOR YOUR TRANSFER LETTER

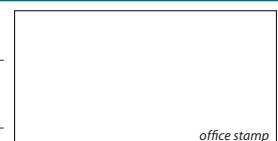
Please see attached transfer letter

SUGGESTED TOPIC	SUGGESTED CONTENT
Recommendations for Future Care	<ul style="list-style-type: none"> • Condition-specific and potential complications/late effects • Recommended investigations • Specialty-specific considerations • Ongoing, regular bloodwork
Condition Specific Information (For each condition)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Specific concerns re mental health and/or substance use
Psychosocial Considerations	<ul style="list-style-type: none"> • Psychosocial information e.g. behaviour/safety concerns, family dynamics, compliance with treatment
Past Medical History	<ul style="list-style-type: none"> • Problem List (date, event or diagnosis, outcome and plan)
Medications	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Lab reports, specialist consults and allied health provider reports
Allergies	
Immunizations	<ul style="list-style-type: none"> • Condition-specific immunizations protocols and alerts • Rationale for non-completion of recommended schedule • What future immunizations are required
Transfer of Care	<ul style="list-style-type: none"> • 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



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

<p>Communication:</p> <p>What is the language the patient speaks? _____</p> <p>And the family? _____</p> <p>Need Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____</p> <p>Communication Strategies and Barriers (please describe below): _____</p> <p>Disability:</p> <p>Mobility: _____</p> <p>Cognitive Disability:</p> <p><input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> None</p> <p>Adaptive Disability:</p> <p><input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> None</p> <p>Living Arrangements:</p> <p><input type="checkbox"/> With family <input type="checkbox"/> On own <input type="checkbox"/> Foster care <input type="checkbox"/> Other</p> <p>Current/Future Plans:</p> <p>Current School: _____</p> <p>Individual Education Plan (IEP): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Post-Secondary Plans: <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Wants a job</p> <p>Other: _____</p>	<p>Benefit Status:</p> <p>Financial/Medication Assistance:</p> <p><input type="checkbox"/> Medical Services Plan (MSP)</p> <p><input type="checkbox"/> Fair Pharmacare <input type="checkbox"/> Pharmacare Special Authority in place</p> <p><input type="checkbox"/> Plan W (formerly Non-Insured Health Benefits for First Nations and Inuit - NIHB)</p> <p><input type="checkbox"/> Extended Health</p> <p><input type="checkbox"/> Interim Federal Health Program</p> <p><input type="checkbox"/> Disability Tax Credit</p> <p><input type="checkbox"/> Private</p> <p>Does this individual identify as an Aboriginal person, that is, First Nations, Métis or Inuit? <input type="checkbox"/> Yes <input type="checkbox"/> No Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eligibility: <input type="checkbox"/> Community Living BC <input type="checkbox"/> People With Disabilities</p> <p style="padding-left: 20px;"><input type="checkbox"/> Choices in Support of Independent Living <input type="checkbox"/> Plan G</p> <p>Financial Ability to Pay for Meds/Equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other Considerations: Are the following in place?</p> <p>Driver's License: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no: Click here for Fitness to Drive Guidelines</p> <p style="padding-left: 20px;">Click here for information on the GF Strong Driver Rehab Services</p> <p>Medical Orders for Scope of Treatment (MOST): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>"No CPR" Form: <input type="checkbox"/> Yes (if yes, please attach a copy) <input type="checkbox"/> No</p> <p>Palliative Care: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Advanced Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Representation Agreement: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Power of Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	---

ABRIDGED TRANSITION CLINICAL PATHWAY (complete pathways for complex and simple are [available here](#))

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

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

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.