



BC PEDIATRIC SOCIETY NEWSLETTER THE PRESCRIPTION PAD

MARCH 2018 ISSUE

Transitioning Patients from Community Pediatricians into Adult Care Project:

Tips for making the Medical Transfer Summary work for you

— Dr. Aven Poynter

The BC Pediatric Society Medical Transfer Summary (MTS) is a 1- or 2-page form to help you transfer patient information when a youth ages out of pediatric care.

The Summary reflects input from key stakeholders including many physicians throughout BC (over 60 community pediatricians, family physicians and adult specialists). It includes information that community pediatricians deemed important to relay to their colleagues and that family physicians and adult specialists said would be useful for them to receive.

The Medical Transfer Summary can be used in various formats, reflecting the range of community pediatrician transition practices and environments throughout BC:

- **EMRs** - Accuro, Plexia, MOIS, Osler, MedAccess, Wolf, IntraHealth - *in process*
- [Letter size PDF](#) download and print the PDF to manually enter information)
- [Fillable](#) (enter information electronically online and save to your desktop)
- **Guide to dictation** (provides a few reminders when using established office transition procedures)

Click [here](#) to visit the BCPS Transition/Transfer website and view additional resources developed by BC Pediatric Society in consultation with community pediatricians and their colleagues.

“The [Transition/Transfer] package is pretty **comprehensive**, so if you need a tool this is **a good one.**”
– Dr. Wilma Arruda

“The form helped me modify what I usually do, and do it **with more clarity.**”
– Dr. Manoj Parameshwar

“I have used the MTS form and found it to be a **good guide**, in particular the suggested **outline for the transfer letter.**”
– Dr. Carrie Fitzsimons

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What pediatricians are saying about the new Medical Transfer Summary

“Transitioning Patients from Community Pediatricians into Adult Care” is a project supported by the Specialist Services Committee (SSC) a partnership of Doctors of BC and the BC government



THE PRESCRIPTION PAD TRANSITION/TRANSFER TO ADULT CARE

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 (MFP)
 Adult Specialist(s)
 Patient
 Parent/Guardian
 BCCH Specialist

Identified	Site Applicable	Not Applicable	Adult Healthcare Team Members	Phone	Fax
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Physician:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult Specialist:		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult Specialist:		

Please use this space to list other members of the adult healthcare team as applicable:

<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/side 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 findings, 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 a.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 Pharmacist 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: _____

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 Dr. Tom: www.ubc.ca BCPS Medical Transfer Summary | 2017/02/21 | Page 1 of 2

Adult Health Care Team – useful to list “adult care providers” in one place. Helps to indicate if any new referrals to adult specialists need to be made before or after transfer.

Transfer Letter – equally good as an outline or reminder

Important information can come from families - download a copy for the patient and family to complete or work through the form with them.

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

Communications: What is the language the patient speaks? _____ And the family? _____ Need Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____ Communication Strategies and Barriers: _____	Benefit Status: Financial/Medication Assistance: <input type="checkbox"/> Medical Services Plan (MSP) <input type="checkbox"/> Care Pharmacare <input type="checkbox"/> Pharmacist Special Authority in place <input type="checkbox"/> One of the benefits from Inwood Health Benefits for First Nations and Inuit (NHBI) <input type="checkbox"/> Extended Health <input type="checkbox"/> Incom Federal Health Program <input type="checkbox"/> Disability Tax Credit <input type="checkbox"/> Private
Disability: Mobility: _____ Cognitive Disability: _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> None Adaptive Disability: _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> None	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 Eligibility: <input type="checkbox"/> Community Living BC <input type="checkbox"/> People With Disabilities <input type="checkbox"/> Children's Bureau of Independent Living <input type="checkbox"/> PlanS
Living Arrangements: <input type="checkbox"/> With family <input type="checkbox"/> On my own <input type="checkbox"/> Foster care <input type="checkbox"/> Other _____ Current/Future Plans: Current School: _____ Individual Education Plan (IEP): <input type="checkbox"/> Yes <input type="checkbox"/> No Post-Secondary Plans: <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Wants a job <input type="checkbox"/> Other: _____	Financial Ability to Pay for Meds/Equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Considerations: Are the following in place? Driver's License: <input type="checkbox"/> Yes <input type="checkbox"/> No If no: Click here for Information to Drive Guidelines <input type="checkbox"/> Click here for information on the BC Strong Drive Rehab Services Medical Orders for Scope of Treatment (MOST) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No CRF Form <input type="checkbox"/> Yes (if yes, please attach a copy) <input type="checkbox"/> No Palliative Care: <input type="checkbox"/> Yes <input type="checkbox"/> No Advance Directives: <input type="checkbox"/> Yes <input type="checkbox"/> No Representation Agreement: <input type="checkbox"/> Yes <input type="checkbox"/> No Power of Attorney: <input type="checkbox"/> Yes <input type="checkbox"/> No

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

	Patient		Parent/Guardian (proximate)	
	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 medical 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 (STI)	<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 formalized for guardianship and future financial planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Psycho-social information family physicians find especially important – family can provide information

Special Considerations – Quick notes for reference by subsequent physicians

A closer look at the Medical Transfer Summary