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
❑	❑	❑	Family Physician:		
❑	❑	❑	Adult Specialist: Purpose:		
❑	❑	❑	Adult Specialist: Purpose:		
Please use this space to list other members of the adult healthcare team as applicable:					
❑	❑	❑			
❑	❑	❑			
❑	❑	❑			
❑	❑	❑			

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