UC Irvine Health

In-Patient Transfer Request (Part I)

(Please Complete Entire Forms Utilizing Fillable Option & Email to TransferCenterStaff@hs.uci.edu)

Transferring Facility Information

TC Staff Name		**Date & Time of Call**		**MR #**	
Initial Caller Name & Title		**Phone #**		**Fax #**	
2nd Caller Name & Title		**Phone #**		**Fax #**	
Referring FACILITY				CHECK HERE IF HLOC →	☐
Referring/Primary MD		**Direct Phone #**			
Secondary/Specialist MD		**Direct Phone #**			

Admission Date		**Unit**		**Unit Phone #**								
Patient Last Name		**Patient First Name**										
DOB		**Age**	(YEARS)	(MONTHS)	**Sex**	(FEMALE) ☐	(MALE) ☐	(X/NB) ☐	**Ht**		**Wt**	☐ Lbs ☐ Kgs
Diagnosis												
Plan of Treatment/ Reason for Transfer												

Level of Care (CHOOSE ONE)				**Sitter**	**Jehovah Witness** (Bloodless)	**Capitated**	**Isolation**	Type of Isol
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
☐	**ICU**	☐	**TELE**	**Code Status** (CHOOSE ONE)		**GCS** (Example: 4 – 6 – 5 = 15)		
☐	**SDU**	☐	**MS**	☐ **Full Code** ☐ **Full DNR**		– – =		
☐	**IP to Procedure Area**			☐ **Modified Code/DNR**		IF GCS IS < 15 THEN ALL 3 #'s MUST BE WRITTEN IN		

Comorbidities

(Please Mark all that Apply) RF Score

	None (0 points)		Stroke/TIA (1 point)		CHF (1 point)		CKD/ESRD (1 point)
	LOS > 2 Weeks (16 points)		Unconscious/ ALOC (2 points)		COVID POSITIVE (16 points)		Immunocompromised / HIV (1 point)
	Out of Service Area (10 points)		DNR Code Status (10 points)		HTN (1 point)		Psych Background (2 points)
	Non-Compliant with Care (1 point)		Diabetes/ Skin Issues (1 point)		MI/ANGINA/ CAD (1 point each)		Unable to Perform ADL's (1 point)
	Social Situation: Drug/ Alcohol Dependence (2 points each)				Lymphoma/ Leukemia/ Cancer (1 point)		Other: (1 point per DX)
	Recent Surgery performed at UCI: (2 points)				Malnutrition/Obesity /Digestive Disease (1 point)		
	Recent Surgery NOT performed at UCI & Is Related to Reason for Transfer: (16 points)				COPD/ Respiratory Failure Ventilated (ETT/Trach) (1 point each)		
	Pulmonary HTN (2 points)				Pulmonary HTN on prostacyclin (2 points)		

POINTS ALGORITHM: * * FOR OFFICE USE ONLY * *

FOR POINTS THAT ADD UP TO 15 OR LESS, NO CLINCIAL REVIEW REQUIRED

FOR POINTS OF 16 OR HIGHER, CLINICAL REVIEW BY HOUSE SUP &/OR NURSE NAVIGATOR REQUIRED

TOTAL POINTS

Comments

Additional Information

Dialysis Patient Y ☐ N ☐

Ventilated (Trach/ETT), BiPAP or Drips Y ☐ N ☐ **Services Available** Y ☐ N ☐

LifeImage Upload Requested Y ☐ N ☐ N/A ☐ **Pt/Family Consent to Transfer** Y ☐ N ☐

Sending Unable or Refusing to use LifeImage AFTER Support Offered - CD Requested Y ☐ N ☐ N/A ☐

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UC Irvine Health

UCI Infectious Disease Screening Form

Please answer the following questions

	Y	N
1.Does the patient have cold or flu like symptoms? (e.g. Fever ≥ 99°F in the last 24 hours, chills, new cough, new shortness of breath, muscle aches, unexpected fatigue, sore throat, headache, diarrhea, nausea, or change/loss of taste or smell with unknown cause or other cold symptoms?	☐	☐
2. Does the patient have a new rash with unknown cause?	☐	☐
3. Have you been in direct contact with a person who has laboratory confirmed COVID-19 in the last 14 days?	☐	☐
4. Have you been diagnosed with COVID-19 or tested positive at a non-UCI lab? If YES, please specify dates: _____	☐	☐
5. Do you have any sick household members or been in close contact with someone who has cold or flu-like symptoms in the last 14 days?	☐	☐
6. Has the patient been exposed to anyone with the measles in the last 21 days?	☐	☐
7. Have you traveled outside of the United States in the last 30 days? (If YES, please answer additional questions 8, 9, and 10. If NO, skip to question 11)	☐	☐
8. Did you travel to the Arabian Peninsula in the past 14 days? (Bahrain, Iraq, Iran, Israel, The West Bank Gaza, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Syria, Unite Arab Emirates, Yemen &/or Lebanon?	☐	☐
9. Did you travel to Africa in the past 21 days? (Democratic Republic Congo, Zaire-East Congo, Former Belgian Congo, Congo-Kinshasa, &/or The Congo)	☐	☐
10. If the patient answered YES to either of the questions 8 or 9, does the patient have any of the following: respiratory illness, pneumonia, fever, cough, shortness of breath, nausea or vomiting, or ARDS	☐	☐
11. Has the patient been admitted to any of these facilities since July 1, 2020? ☐ Kindred Hospital - Westminster ☐ Kindred Hospital -Los Angeles ☐ Kindred Hospital – Paramount ☐ Kindred Hospital-Baldwin Park ☐ Kindred Hospital-South Bay ☐ Kindred Hospital-San Gabriel Valley ☐ Kindred Hospital - La Mirada	☐	☐
12. Does the patient have current or previous infection or colonization with Multi Drug Resistant Organisms (examples: MRSA, CRE, ESBL, VRE, C. difficile, C. auris)? If yes, list microorganism(s): _____	☐	☐
12. Does the patient have an active communicable disease (examples: disseminated shingles, norovirus, TB, etc.) or other condition (e.g. lice, scabies)? List disease(s)/condition(s): _____	☐	☐

Please Email this Completed Sheet (If not completed already) **AND Please <u>Fax the Clinicals to 855-240-1373</u>**

☐ Sent ☐ Will Send ☐ N/A	Face Sheet
☐ Sent ☐ Will Send ☐ N/A	H&P (History and Physical), Progress & Consultation Notes
☐ Sent ☐ Will Send ☐ N/A	3 Days of Lab All Results **Including a COVID result within the last 72 hours
☐ Sent ☐ Will Send ☐ N/A	Any Diagnostic Reports (MRI, CT, X-Ray, EKG, Etc.)
☐ Sent ☐ Will Send ☐ N/A	Medication List