TRANSFER-IN SUMMARY REPORT

Providence Regional Medical Center

Outside Hospital to PRMCE

→ Please FAX to: 425-261-3610 & Send with Patient

Date:_____

Patient name: _____ DOB:_____/_____/_____
Last Name First Name

Age:_____ ☐ Male ☐ Female

Transferring diagnosis/Injuries: _____

Mechanism of injury: _____

Worst vitals: BP: _____ P:_____ RR:_____ T:_____ O2 Sat:_____ on _____ Vent: ☐ Y ☐ N

Current vitals: BP: _____ P:_____ RR:_____ T:_____ O2 Sat:_____ on _____ Pain Scale:_____

Mental Status: A&O x_____ GCS: _____ IVs (Type/Rate) #1 _____ #2 _____ #3 _____

Central Line: ☐ Y ☐ N Foley: ☐ Y ☐ N Blood: ☐ Y ☐ N _____
Blood Products Given

Allergies: _____ ☐ NKDA NPO Since: _____

Meds given: _____

Treatments/Procedures: _____

Imaging:_____ Images sent electronically (PACS):_____

Relevant/Critical Labs: _____

Psychosocial info / unusual occurrences: _____

Notes: _____

_____

_____

Clearly marked personal belongings: ☐ Y ☐ N

Expected time of arrival: _____ Method of Transport: _____

Facility _____ Sending Provider: _____

Nurse: _____ Nurse Phone:_____

PROVIDENCE
Regional Medical Center
Everett

Colby Campus • 1321 Colby Ave.
Pacific Campus • 916 Pacific Ave.
Pavilion for Women and Children • 900 Pacific Ave.
Providence Regional Cancer Partnership
1717 13th Street • Everett, WA 98201

60179 (6/12/18)

PLACE PATIENT LABEL HERE

Patient Name:_____

Birthdate: _____

DO NOT WRITE OUTSIDE OF BORDER AREA