



MEDICAL TRANSFER FORM

NAME DATE OF BIRTH

HOSPITAL NUMBER WARD

DATE OF ADMISSION DATE OF TRANSFER

ADDRESS

GENERAL PRACTITIONER CONSULTANT

REASON FOR ADMISSION TO HOSPITAL

REASON FOR TRANSFER TO HOSPICE SYMPTOM CONTROL
TERMINAL CARE

RESULTS OF INVESTIGATIONS AND TREATMENT PLAN
(please attach copies of recent imaging results and latest blood results)

IS THE PATIENT FOR RESUSCITATION?	YES	NO
Discussed with patient?	YES	NO
Discussed with family?	YES	NO

If family, who?

CURRENT MEDICATIONS

PLEASE SEND COPY OF DRUG CHART WITH MEDICAL NOTES AND NURSING TRANSFER LETTER

COMPLETED BY FY1 OR 2 / SHO / SPR / CONS

BLEEP NO. DATE