**FORM 52**

# Patient Transfer Form

SWARG COMMUNITY CARE

**Core Elements**

**Last name:** _____ **First name:** _____ **DOB:** _____ **Age:** _____ **Sex:** M / F

**Date of transfer:** _____ **Time of transfer:** _____ **am/pm**

| | |
|---|---|
| Transferring facility: | Contact number: |
| Transfer to: o Home o Hospital o Other facility | |
| Name of facility: | |
| Patient Guardian name: | |
| Patient Guardian contact number: | |
| Reason for transfer/continued care: | |
| Diagnosis: | |
| Current Medical & Physical Condition: | |
| Current Medication: | |

**Recent Lab Reports sent with patient:** o Yes o No

**Vital signs at time of transfer:** BP:_____ Sugar: _____ T:_____ RR:_____ O2 sat:_____

**FORM COMPLETED BY:** Name _____ Date _____/_____/_____
Time_____

**Time Patient Transferred:** _____

_____ _____

Guardian Signature Swarg Authorized Signature

**Note: Swarg is not liable/responsible for any circumstances after transfer/discharge of patient from the facility.**

Last updated May 2021