BRITISH COLUMBIA CHILDRENS HOSPITAL
INTERHOSPITAL TRANSFER FORM

COMPLETE ON DAY OF TRANSFER

PATIENTINFORMATION

CAPE Unit – BC Children's Hospital
Mental Health Building
Entrance 1, 2nd Floor
4555 Heather Street
Vancouver, BC
Phone: 604-875-2075
Fax: 604-875-2208

To: Referring Physician,
Please read the information provided

From: Child and Adolescent Psychiatry Emergency Unit CAPE

Hospital & Unit:	**Physician:**
Phone:	**FAX:**
Re:	**Date:**

The Child and Adolescent Psychiatric Emergency Unit (CAPE) at BC Children's Hospital has received a request for transfer from your facility. We service children and adolescents up to and including the age of 16 years.

1) **All transfers must be certified – Please fax the documentation to 604-875-2208:**
   - British Columbia Children's Hospital Interhospital Transfer Form
   - Mental Health Act forms 4 and 5
   - The Psychiatric Evaluation
   - Physical Examination and pertinent lab results

   Prior to acceptance: Our Psychiatrist and/or Psychiatric resident will review the above documentation, contact you, advise you of bed availability and inform you if the patient will be accepted for transfer. Patients must be medically stable with documented medical clearance.

2) **Once the patient has been accepted for transfer please:**
   - Contact the CAPE unit at 604-875-2075 to inform them of the transfer arrangements and give verbal Nurse to Nurse handover highlighting safety concerns.
   - Ensure the guardians/caregivers are informed
   - Ensure the patient has all of their personal items
   - FAX or provide photocopies of the patient chart including:
     Physician Orders and documentation
     Medication Administration Records
     Last 72 hours of nursing notes
     Consults including Emergency Room visit
   - Contact the CAPE Unit when the patient departs from your facility

All transfers must be Physician to Physician. Admissions arriving between 09:00 and 16:00 can come directly to the CAPE unit. Admissions after 16:00 must go to emergency, unless a Psychiatrist is available on the CAPE unit to receive them. If CAPE is unable to accept the patient for transfer due to bed availability, call (605-875-2345) the following morning and speak to CAPE attending Psychiatrist to determine bed availability and acceptance for transfer. Special consideration is given to transport via air-ambulance, remote regions, and specific patient circumstances.

Please note: This form must be completed by sending facility prior to acceptance of patient.

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PATIENT INFORMATION *(check all that apply)* Patient Nickname:

☐ **Patient Identity Verified:** [1]: [2]:

Date Admitted to Hospital: MONTH / DD / YY Age:

Est. Date & Time of Admit: MONTH / DD / YY @ TIME

Has a referral been made to another program/institution – YES/NO
If YES, WHERE?:

Equipment Required for Patient:

Legal Guardians (specify relationship to Patient) Contact:

Contact:

☐ Legal Guardians notified: MONTH / DD / YY @ TIME ☐ **MCFD involved?** SPECIFY

☐ **MCFD Alerts:** **Last Residence** ☐ Foster Home ☐ Parents Home ☐ Other/Specify

Diagnoses (Psychiatric and Medical)

Psychiatric Diagnosis:

Infectious Diseases: **Head Lice: Yes/No**

Current Vital Signs: B/P HR Resp Pulse

☐ Substance Use : ☐ Consult Services Involved:

☐ **ALLERGIES:** ☐ NKA ☐ **MEDICAL ALERTS:** (e.g. sutures, burns, tubes, seizures, etc.)

RISK ASSESSMENT

☐ SUICIDAL IDEATION: ☐ Active /Recent: MONTH / DD / YY ☐ in History ☐ Attempts

☐ Self-Injury:

☐ Aggression ☐ Physical ☐ Verbal ☐ Homicidal Ideation

☐ Active Psychosis ☐ Delusions ☐ Hallucinations *Specify:*

☐ Elopement Risk Other Precautions:

☐ Last Time Seclusion Needed MONTH / DD / YY

Special Observation Level: ☐ 1:1 Supervision ☐ Constant Obs. ☐.Other/please specify

Reason for Level:

MEDICATIONS ☐ N/A

☐ Last scheduled medication administered:

☐ Next medication dose due:

☐ Last PRN medication administered: @ TIME MONTH / DD / YY

@ TIME MONTH / DD / YY

@ TIME MONTH / DD / YY

MENTAL HEALTH ACT FORMS

Certification: ☐ YES ☐ Involuntary Form 4 & 5 completed ☐ Form 13 (rights)

☐ NO ☐ Voluntary Form 1 & 2 completed ☐ Form 14 (rights)

Form initiated by:	*(RN SIGNATURE)*	@	TIME MONTH / DD / YY
Form received by:	*(RECEIVING NURSE SIGNATURE*		TIME MONTH / DD / YY

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